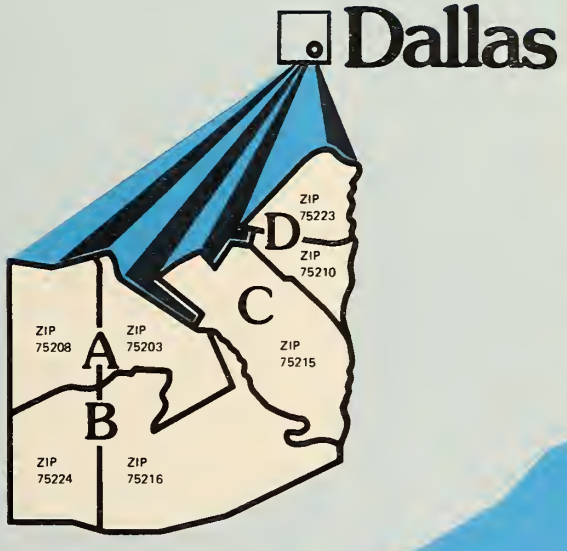
EVALUATION REPORT PHASE 2 Feb - Dec 1976

EPSDT Demonstration in an Urban Setting Dallas, Texas



Prepared by
Health Services Research Institute
The University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive
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Prepared under a grant awarded by the Social and Rehabilitation Service, DHEW

34.

SECOND EVALUATION REPORT

SRS/DHEW Demonstration Project

EPSDT IN AN URBAN SETTING - DALLAS, TEXAS

Period Covered - February 1, 1976 - December 31, 1976

Health Services Research Institute
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May 15, 1977

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HEALTH SERVICES RESEARCH INSTITUTE

(HSRI)

University of Texas Health Science Center at San Antonio

The Health Services Research Institute (HSRI) was originally established in 1972 as a component of The University of Texas Health Science Center at San Antonio to serve as a Regional Research Institute of the Social and Rehabilitation Service, DHEW to provide consultation and assistance to the five-state DHEW Region VI.

The primary thrust of the Institute was to conduct research to improve the quality and quantity of health programs for the indigent. Though subsequent relationships with SRS diminished and then terminated the Regional Institute role and refocused its activities toward assistance to the central office in Washington and evaluation of the EPSDT program in the national context, the major concentration of the Institute remains unchanged and includes projects in family planning, aging, health manpower and child health (particularly in the area of developmental and emotional assessment and treatment).

The Health Services Research Institute is a team of multidisciplined researchers with individuals trained in economics, medical sociology, psychology, computer science, health management and manpower, and special education. The Institute's association with the University of Texas Health Science Center at San Antonio, which includes medical, dental, nursing and graduate schools, gives staff members ready access to professional consultation in many fields.

Dr. Harry Martin and Dr. Harold Dickson, both members of the medical school faculty, are respectively Director and Deputy Director of the Institute.

SUMMARY

I. History

The Dallas Project--EPSDT in an Urban Setting--was approved and funded by SRS under Section 1115 of the Social Security Act in July 1975. The period from July 1975 to January 1976 was devoted to "start-up" activities. The demonstration phase of the project began in February 1976. The first evaluation report covered the project's activities through June 30, 1976 and largely addressed: the start-up activities; the research objectives; the research design; the setting for the project; the methodologies of data collection; the structure and form of the project evaluation and preliminary data collected in the first months of the project.[1]

II. Project Objectives and Variables Tested This Report Period

A. The major activities of the project for this report were focused on increased participation of the eligible population in the EPSDT program and, when needed, improved rates of health treatment initiations and completions.

B. There has been little evidence from other sources up to this point of the willingness and intent of the total eligible population to participate in the EPSDT program. This point was deemed critical in arriving at any valid conclusions concerning the eligible population's potential participation in the program. The identification of this interest was dependent upon maximally contacting a segment (sample) of the eligible population. The Dallas project undertook this task and, in Sector C, contacted more than 80% of all eligible families. The results of this effort are of significance and contain major issues for consideration by State and National EPSDT program policy makers. These are discussed in the following section of this summary.

C. The specific major variables being tested during the period of this report were:

Case Finding (Increased participation)

- - Full time EPSDT workers of different skill levels employing the same case finding techniques.

- - Full time EPSDT workers of the same skill levels employing different techniques (in-the-home/face-to-face contact as contrasted with a letter/telephone type technique).

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[1]Evaluation Report, Phase I; February - June 1976 - EPSDT in an Urban Setting, Dallas, Texas. Health Services Research Institute, University of Texas Health Science Center, San Antonio, Texas, November 15, 1976.

Case Monitoring

- - Full time EPSDT workers of different skill levels employing standardized follow-up techniques (through contacts with parents and treatment providers).

III. Findings, Conclusions and Implications of Variables Tested this Report Period

A. The findings and conclusions related to these variables are:

1. Case Finding (Personnel)

a. The Test: Determine whether Community Service Aides II, with an annual salary range of $6,624 to $8,352 can be as effective in inducing EPSDT program eligibles to participate in the program as Public Welfare Worker I, with a salary range of from $9,840 to $12,408, both using the same case finding technique of in-the-home/face-to-face contact.

b. The Result: Evaluation of the comparative performance of CSA II's and PWW I's, in terms of (1) rates of contacts of eligibles, (2) contact activity per full time equivalent, (3) rates of appointments made, (4) rates of appointments kept, and (5) associated population penetration rate, indicates that the higher-skilled/higher-paid PWW I's are 1.15 times more cost effective in case finding than the lower-skilled/lower-paid CSA II's.

c. Discussion:

(1) National Implications

Both categories of workers appeared to be successful in "selling" the EPSDT program to their respective contacts when measured in terms of "screening appointment made" of families contacted. They appointed, respectively, 83% (CSA II's) and 88% (PWW I's) of families contacted.

When measured in terms of "first appointments kept", however, they realized in the order of 32% (CSA II's) and 44% (PWW I's) respectively, of those appointed.[1]

Analysis of the situation reveals that in the use of the "in-the-home/face-to-face" contact case finding technique, the "appointment made" is, to many clients, only an "apparent" commitment, whereas the "appointment kept" is the "true" commitment. There is obviously a marked difference between the apparent and true commitment. Programmatically, this is a salient factor in itself. In this project, persistent case finding follow-up on all clients not keeping the first appointment resulted in an additional 14% of those appointed keeping a second appointment and another 3% keeping third appointments. No additional appointment efforts were made beyond the third broken appointment at any annual periodic sequence. In summary, it seems that only a total of 55%, at the most, of those accepting appointments may be considered to have a "true" interest in

[1]With the usual availability of Welfare Department transportation to meet all program needs (not necessarily EPSDT dedicated).

the program and that approximately 43% an "apparent" interest--or are simply not convinced of the value of the program. It may be argued that the initial commitment of many clients (43% at least) to participate in the program may simply be an intent to appease or pacify a case finder in a face-to-face situation. The client may see an overt rejection of the program being viewed by the case finder as an indication of non-cooperativeness, or even, perhaps, as an attitude of indifference toward the well-being of her children. In these terms then, it may well be easier for the client to indicate willingness to participate in the program by accepting an appointment from the case finder and then later, simply not keep the appointment. This, then, is a covert rejection of the program. When some clients in this category then, unexpectedly find themselves being recontacted by the case finder to explain the appointment failure and accept a second appointment, they will "acquiesce" to the continued pressure and accept and keep the second appointment. With other clients in this category, the first appointment failure will have been unintentional and they will willingly accept and keep the second appointment. Both of these elements constitute the 14% and 3% keeping the second and third appointments, respectively. With this as a rationale, it can be stated that the "true" interest in the program is in the order of roughly 50% of those indicating a willingness to participate in a face-to-face program promotion situation.

Conversely, it can be stated that the other 50% have no real interest in the program at this stage of the eligible population's cognizance of preventive health. It is important to reemphasize that this is the situation after one of the most intense outreach efforts employed--face-to-face/in-the-home contact.

From these findings, it becomes evident that the real challenge to the EPSDT policy makers, both at the National and State levels, is in determining the degree of effort, if any at all, they are willing to underwrite to bring this extensive segment of the eligible population into the program.

In an overview sense, much more general preventive health education will have to be undertaken to make serious inroads into this group. This, based upon the current level of "preventive health concern" in the American public, will take years. What are the interim alternatives? What is their likelihood of success? What are their probable costs?

The interim alternatives in a voluntary program to bring high participation rates (higher penetration rates) are more extensive case finding efforts. One such effort would be to intensify the in-the-home/face-to-face contact to include "escorted" service from the home to the screening point and subsequent treatment sites, using program dedicated transportation. Another approach would be to concentrate on screening of school age children through the school system, a point of actual convergence and concentration of children wherein only parent consent[1] would be necessary to initiate the screen and implement the follow-up for required treatment. An all-out outreach effort to bring those families and children not otherwise successfully recruited for the program could be in-the-home screening, a technique tested by Dr. William K. Frankenberg and his associates at the University of Colorado Medical Center and the Denver Neighborhood Health

[1]To include family and child history data.

Program.[1]

It is hypothesized that these increasingly intensified outreach methods would increase the eligible population participation in the program to 80% - 90%.[2] The costs of such activities are largely unknown, but it would appear logical to assume an increasing cost for cases brought into the system.

A proposal has been made to test these alternative case finding methods in the Dallas project for FY 78 to ascertain their probable rates of effectiveness (penetration/participation) and respective costs.

Another concept being considered by the new Administration in Washington is to use the "acute care" episodes of the eligible population as case finding efforts, program the site of this care as the child's "medical home", and subsequently schedule the child for a full evaluation (a health assessment more or less identical to an EPSDT screening). Unknown at this point would be the "true" participation rate of the client population in the sequential preventive health assessment in this program mode. It might well be quite similar to that experienced in the Dallas project (50%). An appropriate demonstration of this concept approach to ascertain probable results appears warranted.

(2) State Implications

There is a definite context of State program implications in the preceeding discussion.

Additionally, the fact that the PWW I's are 1.15 times more cost effective in case finding than the CSA II's, who are, to an unknown extent, utilized in this role in the Texas program, carries the implication that if PWW I's were utilized across the board in this role, there would be a potential dollar saving to the State at designated levels of output.[3]

2. Case Finding (Technique)

a. The Test: Determine whether the project tested technique of employing full time case finders, using in-the-home/face-to-face contact is more effective than the "ongoing" program technique of employing part time case

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[1]"Cost Effectiveness of Screening Children in Housing Projects", Peter Dawson, Marlin Cohrs, Charles Eversole, William Frankenburg, and Monty L. Roth. American Journal of Public Health, December 1976, Vol. 66, No. 12, pp.1194-1196.

[2]Accepting that in a voluntary system, 90% probably represents the highest degree of participation attainable.

[3]The estimated number of EPSDT workers in the Texas program is 250. The degree of saving relates to the degree in which PWW I's and CSA II's are utilized in the Texas program at any designated level of output (client program participation rates (penetration rates)).

finders[1] using a combination of letter/telephone, with both categories of workers being of the same classification (Public Welfare Worker I).

b. The Result: Evaluation of the results of both techniques measured primarily in the terms of the penetration rate (rate of shows for screening of those eligible) indicates that the letter/telephone contact employed by the ongoing program is as effective as the face-to-face/in-the-home technique utilized in the project at relatively the same cost (per full time equivalent) per show for screen.

c. Discussion:

(1) National Implications

The data indicated that the case finding technique of letter/telephone contact can be proximally as cost effective as the face-to-face/in-the-home technique at designated client program participation levels.

It had been anticipated that the performance effectiveness, as distinct from cost effectiveness, would have been much more in favor of the highly personal in-the-home/face-to-face contact technique over the less personal letter/telephone contact technique.

It appears, however, as discussed in the previous test, there is a significant category of clients (approximately 40 - 45%) who, in the face-to-face situation, will express intent to participate but will miss as many as three appointments for screening and, therefore, may be considered to have covertly rejected the EPSDT program.

The letter/telephone approach of soliciting an initial overt client action, such as a return telephone call or letter to demonstrate program interest, may, by its very nature, "sort out" the group that has no true interest in the program. This, in itself, could be a significant savings in unproductive case finding effort for many EPSDT programs. The substance of this premise, however, in itself, establishes a probable client participation ceiling[2] of approximately 45 - 50%, short of long range preventive health education through schools and mass media programs or short range, high intensity case finding activities discussed earlier, such as escorted services, school centered programs, or in-the-home screening.

Program policy makers, both legislative and executive, National and State, must come to grips with these realities of a preventive health program and

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[1]These workers are utilized both as case finders and case monitors. With the changing State emphasis toward follow-up, their time distribution is shifting from a 70% case finding to an approximately 50%. Conversely, their time for case monitoring is shifting from 30% to approximately 50%.

[2]In a continued voluntary mode program.

determine appropriate goals and objectives and allocate resources commensurate with the objectives selected.

All indications are that most of the States, which are traditionally fiscally conservative, have not and will not allocate funds to expand the EPSDT program to that group of clients who, at this point, have no evident true interest in the program. They will make the program available and satisfy the requirements of Federal law and regulations, but they will not undertake the "big sell". As long as this is true, the participating category of client will be generally less than 50% of those eligible. This situation prevails notwithstanding the fact that, as an overall generality, an estimated two-thirds of the program costs are Federally matched.[1]

It may be logically concluded, therefore, that if Federal policy makers (legislative/executive) want to expand the program to include increased percentages of the eligible group, it will have to be through increased Federal share of the total program costs.[2] All available manifestations of State intentions are that they will not increase State dollars for the program above current levels (generally satisfying the minimal requirements of the penalty regulation).

(2) State Implications

There is a definite context of State program implication in the preceeding discussion.

The results affirm the efficacy of the current major thrust of the Texas ongoing case finding technique (letter/telephone) as a means of soliciting the participation of up to 50% of the current eligibles.

As indicated in the preceeding discussion, however, this may well be the upper level of client participation in the program through current expenditures (State share).

3. Case Monitoring (Personnel - Immunization Follow-up)

a. The Test: Determine at which minimum skill level of four categories of case monitors, i.e., Nurse, Public Welfare Worker III, Welfare Service Technician II, and Community Service Aide III, the maximum cost effective rate of immunization completions (current for age) can best be achieved utilizing the same follow-up methodology.

b. The Result: In a preliminary analysis of the data concerning the status of children who were not current for age at completion of screening, only 5% were brought to a status of current for age four months later through

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[1]This represents the totality of EPSDT program cost to include case finding, screening, diagnosis, treatment, case monitoring and program management.

[2]Or, through clear and obvious demonstration, that seeking out the nonparticipating 50% + of the eligibles will result in tremendous short range cost/benefits.

follow-up activity. A revision of procedures was immediately adopted (September 1976). Immunization follow-up has been deferred for definitive evaluation until report No. 3.

c. Discussion

(1) National Implications

Notwithstanding the current limitations on the adequacy of the data base, there appears to be sufficient operational evidence to justify comment on efforts to follow up on immunizations not "current for age" at completion of screening. The case monitors, attempting, through repeated contacts with parents, to improve the rate of children current for age in their immunizations, report that many parents are basically indifferent to the requirements for "current for age" status. As for EPSDT as a preventive health program, there is a broad base of unawareness of the role of preventive health and immunization, both in a positive and negative sense--what is prevented and the consequences of non-prevention. The case monitors find that many parents will accept immunizations for their children while present at a health care delivery activity for some other purpose, such as screening, treatment, etc., but normally will demur from making any "special" trip to a clinic and other health activity solely for that purpose.

As for EPSDT in general, to overcome this situation for children over six in States in which there is no legal requirement for designated immunizations for school admission[1] or for pre-school children, it will require long range preventive health initiatives and short range aggressive outreach efforts. Possible short range approaches could be maximizing immunizations at all normal encounters of children with the health care delivery systems[2] and assuring adequate reimbursement to providers (both public and private), or taking immunization programs to "neighborhoods at risk" through means of mobile immunization clinics in neighborhood housing areas or immunization stations at super markets, etc.

A related and compounding aspect of the overall problem that emerges from other projects and surveys of the EPSDT program in other States is that immunization policy will frequently differ between practitioners, sites and jurisdictions as to the administration of immunizations under circumstances in which the parent has no records and is uncertain as to whether the child had previously received the immunization. Some authorities advocate a policy of "when in doubt, immunize"; others refrain from administering immunizations under such conditions.

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[1]Significant to this whole problem of reservoirs of unimmunized children is the recent epidemic (April 1977) of rubeola measles in Los Angeles, California, wherein it was reported that half of the 2,300 victims of the disease were school age children who were "presumed" to have been immunized in accordance with State law requiring immunization as a prerequisite to school admission.

[2]Where not contraindicated by the acute condition under treatment.

There appears to be a need for some national health policy statement concerning administration of immunizations, wherein the status of the series or single immunization is uncertain, if long range and short range aggressive outreach immunization programs are to succeed.

4. Case Monitoring (Problem/Case Completion)

a. The Test: Determine at what minimum skill level of four categories of case monitors, i.e., Nurse, PWW III, WST II, and CSA III, the maximum rate of immunization completions, problem completions, and case completions can best be achieved, utilizing the same follow-up methodology.

b. The Result: (Deferred until the Phase III report. The caseload that developed was inadequate to complete this test during this project period due to a significantly decreased project population and significantly fewer health problems identified than originally projected.)

IV. General Project Program Performance Factors

A. General Project Program Performance

Immediately following are schemata representing the tracking of all family contacts (495)[1] made by the project from July 1 to December 31,1976 from point of outreach contact to problem completion or other administrative termination.

Schema 1 is the tracking of combined original contacts and periodic recontacts.

Schema 2 is the tracking of the original contacts only.

Schema 3 is the tracking of the periodic rescreen contacts only.

A summation of selected primary program effectiveness indicators contained in these schemata follows. These indicators are considered to be quite reflective of the general status of the project's supporting program. Specific analysis of components being tested are addressed elsewhere in this report.

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[1]Representing 1,316 children.

Table of Primary Program Effectiveness Indicators Derived From An Analysis of 495 Family Contacts (July 1 - December 31, 1976)

	Overall	Original Screens	Periodic Rescreens
1. Of Families contacted - agreed to participate in the program	88%	88%	94%
2. Of children of families willing to participate - accepted screening appointments	99%	99%	98%
3. Of children appointed for screening - showed for screening[1]	57%	58%	52%
4. Of children screened - had medical problems	11%	9%	25%
5. Of problems identified in screening - showed for treatment	68%	78%	44%
6. Of problems showing for treatment - confirmed at diagnosis and treatment	83%	88%	73%
7. Of problems confirmed - successfully resolved	60%	55%	-[2]
- administratively terminated	7%	8%	-[2]
- still pending	33%	37%	-[2]

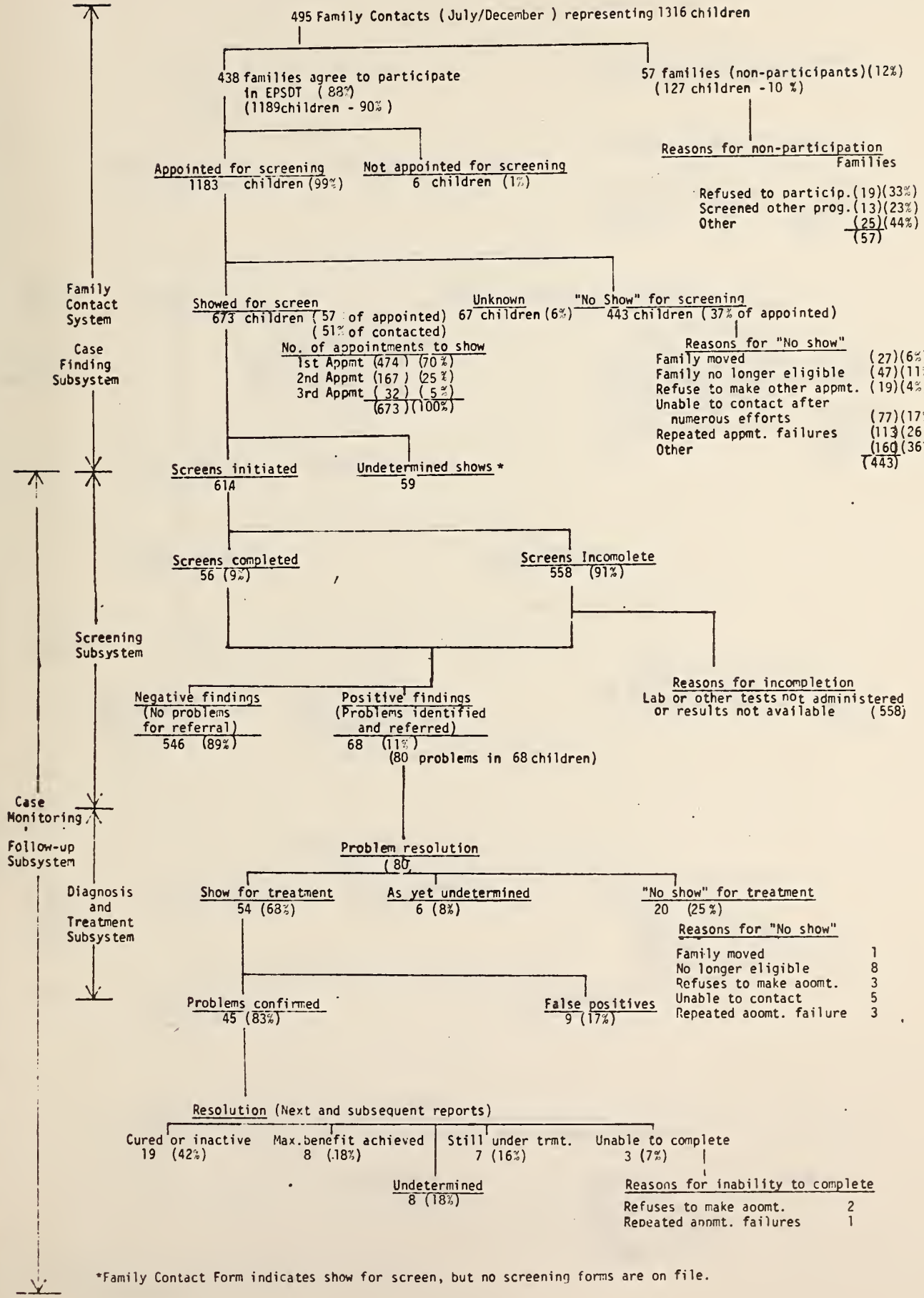
[1]To a total of three appointment attempts.

[2]The numbers become too small at this point to be representative and, therefore, are omitted (see schemata).

The 40% loss of "presumably" committed clients reflected above between the appointments accepted (two) and appointments kept (three) is the major topic of analysis of this report.

The low rate of problems found at original screening (9%) in the Dallas project area is most unique, both within the State and nationally. The contrasting 2.8 times higher rate of problems found in rescreen (25% - line four) deviates significantly from expectations based upon other project and operational data, particularly in consideration of the low original screening problem rate. This factor will be followed as a larger data base is gathered.

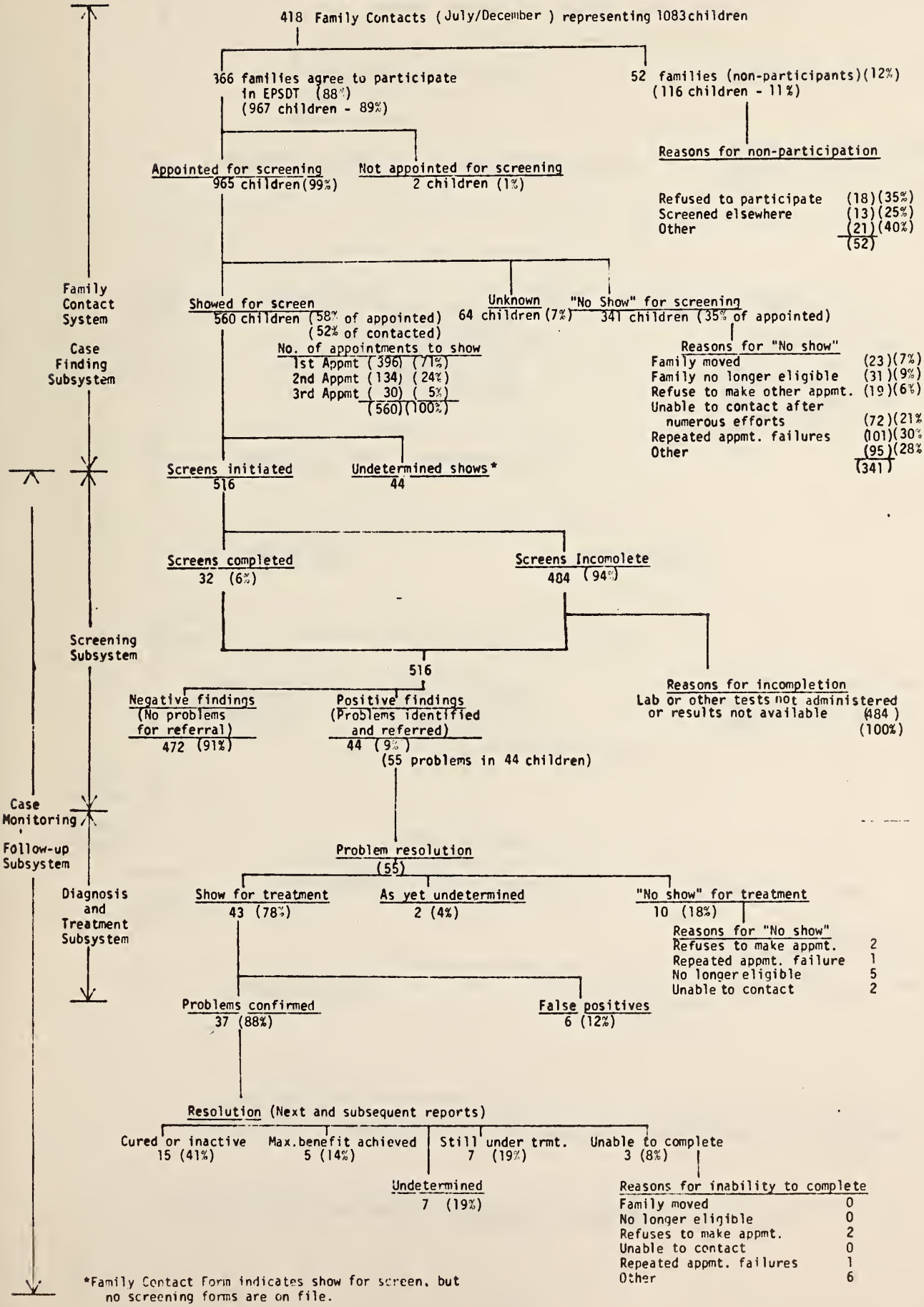
A "TRACK" THROUGH THE EPSDT PROGRAM OF 495 FAMILY CONTACTS
MADE IN JULY - DECEMBER 1976
DALLAS PROJECT



*Family Contact Form indicates show for screen, but no screening forms are on file.

A "TRACK" THROUGH THE EPSDT PROGRAM OF 418 FAMILY CONTACTS
MADE IN JULY - DECEMBER, 1976
DALLAS PROJECT

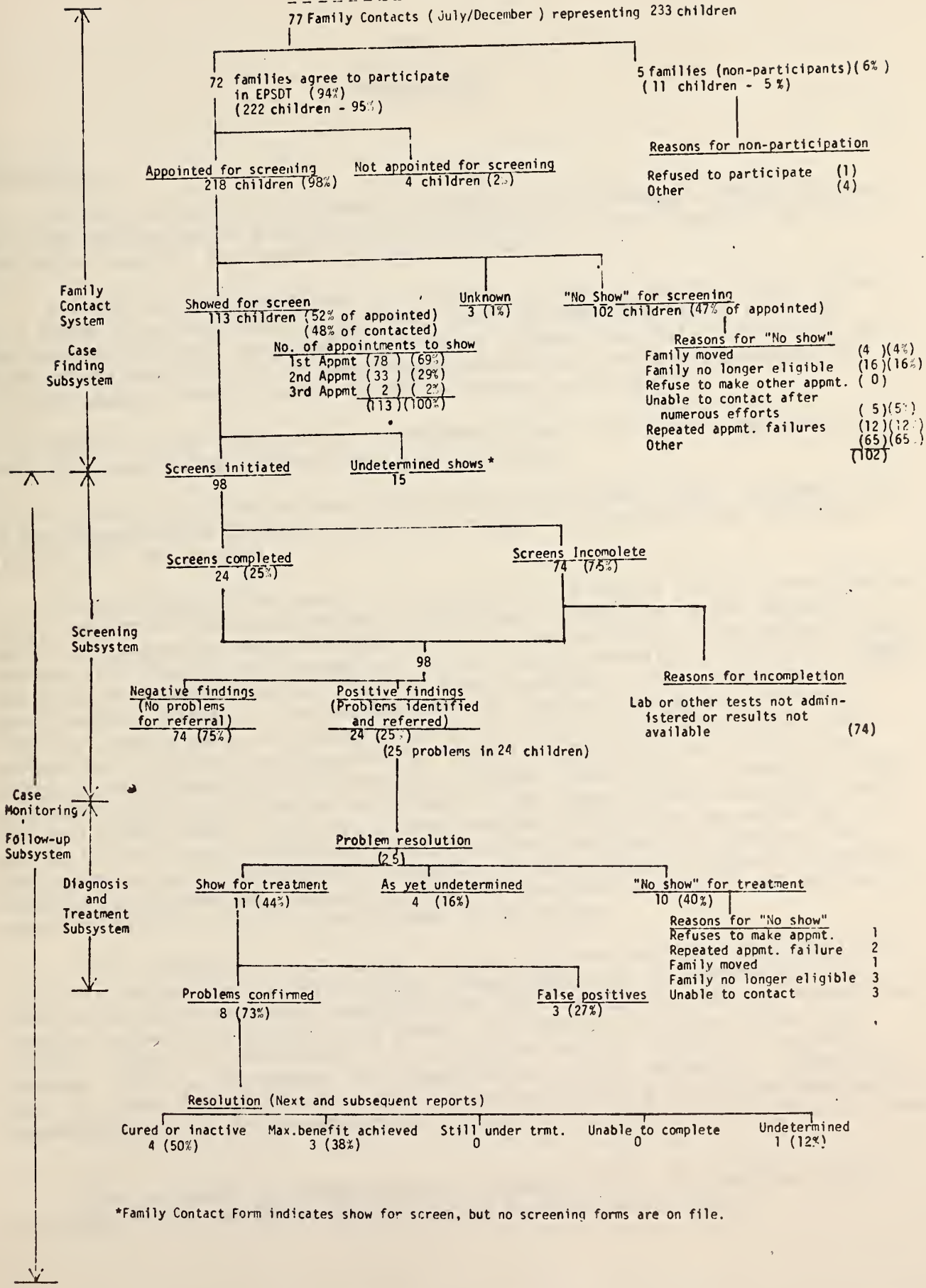
ORIGINAL SCREENS



*Family Contact Form indicates show for screen, but no screening forms are on file.

A "TRACK" THROUGH THE EPSDT PROGRAM OF 77 FAMILY CONTACTS
MADE IN JULY - DECEMBER 1976
DALLAS PROJECT

PERIODIC RESCREENS



*Family Contact Form indicates show for screen, but no screening forms are on file.

CHAPTER I

INTRODUCTION

Background

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program was enacted into law as a section of Title XIX of the Social Security Act by the Social Security Amendments of 1967 (PL90-248).

Through this amendment Congress intended to require states to take aggressive steps to screen, diagnose and treat poor children with health problems. The Congress had been concerned about the variations from state to state in the rates of children treated for handicapping conditions and health problems that could ultimately lead to costly chronic illnesses and disability.

EPSDT, in the ideal sense, is intended to be a program for comprehensive preventive and health services for "poor" children.

It was then estimated that approximately ten million "poor" children (12% of the United States child population) throughout the United States would be eligible for the program.

Notwithstanding the intent of the program, the unique federal-state sharing of its responsibility still reflects significant variations in the degree to which the program has been implemented by the various states. The federal agency charged with program implementation, the Social and Rehabilitation Service, DHEW,[1] has acted in several ways to bring the lower spectrum of variability to a minimum standard. First, in conjunction with the Congress, there was enacted a "penalty" provision to the Social Security Act for failure of a state to meet certain basic program requirements for informing eligible clients, providing screening when requested, and providing treatment when needed. Secondly, it has provided significant technical assistance to the states through contracts and regional office staff. Thirdly, it has devoted considerable resources to: (1) evaluation and identification of "best practices" and "program barriers" for dissemination to the states and (2) conduct of demonstration projects to develop information systems and innovative, effective and cost beneficial methods for providing EPSDT services for assistance to the states.

It is primarily in this latter context that the Health Services Research Institute, University of Texas Health Science Center at San Antonio has been involved with SRS and EPSDT programs since 1972. Initially, SRS had funded four separate projects in Contra Costa County, California; Cuba, New Mexico; San Antonio, Texas; and Washington, D.C. to explore various aspects of the EPSDT program. Shortly thereafter, SRS requested the HSRI to establish a common data base for these four projects in order to evaluate their programs and provide recommendations to SRS concerning utilization of findings in a multitude of state

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[1] SRS, as such, was discontinued in February 1977. The function is now assigned to the new Health Care Financing Administration, DHEW.

programs (technical assistance). This activity has been, and is scheduled to continue, through the phase-out of these projects in 1975 - 1977.

In 1975, the directive staff of the Office of Planning, Research and Evaluation (OPRE) SRS, prescribed a more formal and structured approach to research and demonstration. In this context, HSRI developed a comprehensive research design with a common data base for interrelated research projects[1] to be undertaken in several urban sites of high eligible population density. These projects were to be predicated upon maximizing the use of the inbeing health care delivery systems, focusing on new and innovative techniques for getting poor children into the health system (case finding/outreach) and, when appropriate, holding them there until their health needs were met (case monitoring: screen completions/treatment initiation/treatment completion). Three proposals (projects) were funded by SRS in FY 76 under this "grand design"; i.e., New York City, N.Y.; Miami, Florida; and Dallas, Texas, for the first year of three year projects. Intermeshed in major personnel changes in the OPRE/SRS directive staff in 1975-76, however, were further changes in research concepts and priorities, with less emphasis on "pure" research design. As a consequence, the three projects became "independent" of each other, with the Dallas project being the only one remaining within the original context for evaluation by the HSRI. Its major thrust continued unmodified as the "development of innovative, effective, and cost beneficial methods of case finding and case monitoring for the EPSDT program in an urban environment."

The Dallas project -- EPSDT in an Urban Setting - Dallas, Texas -- was approved and funded by SRS under Section 1115 of the Social Security Act in July, 1975. It initiated methodological variations in February, 1976. It was refunded for continuation in July, 1976, with some redirection toward greater emphasis on reflecting the current programmatic informational needs of the Medical Services Administration, SRS; e.g., the older child, the role of the school, and interagency collaboration.

Project Structure

As depicted on the cover the project area is a sub-component of the City of Dallas made up of seven zip code areas, organized into four sectors, three of which are structured for experimental variations (Sectors A, B & C) and one as a control (Sector D). The control is intended to represent the activities of the "on-going" prescribed EPSDT program. An arrangement that has evolved[2] since the project's original submission is the presence of both "on-going" and "project" EPSDT activities in Sectors A, B & C. In effect, 40% of the eligible clients living in Sectors A, B & C are "project" (those whose medicaid numbers end in 3, 5, 7 & 9) and 60% are"on-going" (those whose medicaid numbers end in 0, 1, 2, 4, 6, 8). A detailed presentation of this distribution is as follows:

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[1] Evaluation Handbook, EPSDT Evaluation Model, HSRI, May 1, 1975.

[2] See Chapter VI for background.

DISTRIBUTION OF EPSDT PROGRAM ELIGIBLES BY SECTOR
PROJECT AND "ON-GOING"[1]

Sector	Zip Code Area	EPSDT ELIGIBLES Total (100%)	Project (Approx. 40%)	On-Going (Approx. 60%)
A/B (A - J)*	75203 75208	3,583	1,378	2,205
(K - Z)*	75216 75224	3,328	1,280	2,048
C	75215	3,684	1,417	2,267
D (control)	75210 75223	3,086	(1,187)[2]	1,899
		13,681[3,5]	4,075 [4] (5,262)	8,419

Major Project Variables

The major variables being tested in this report period were:

Case Finding

.. test the use of full time case-finding aides of varying skills doing in-the-home/face-to-face contact with clients to determine what client program participation rates could be achieved, at what cost, and as compared to each other (skill levels) and to "ongoing" (control).

..test the use of a specially designated "Young Adult Screening Clinic" (YAC) as a means of affording greater participation of eligible teenagers in the EPSDT program.

Case Monitoring

..test the use of full time case monitors of varying skills to determine what problem and case completion rates could be achieved, at what costs, and as compared to each other (skill levels) and to "ongoing" (control).

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[1]Approximately December 31, 1976.

[2]Control

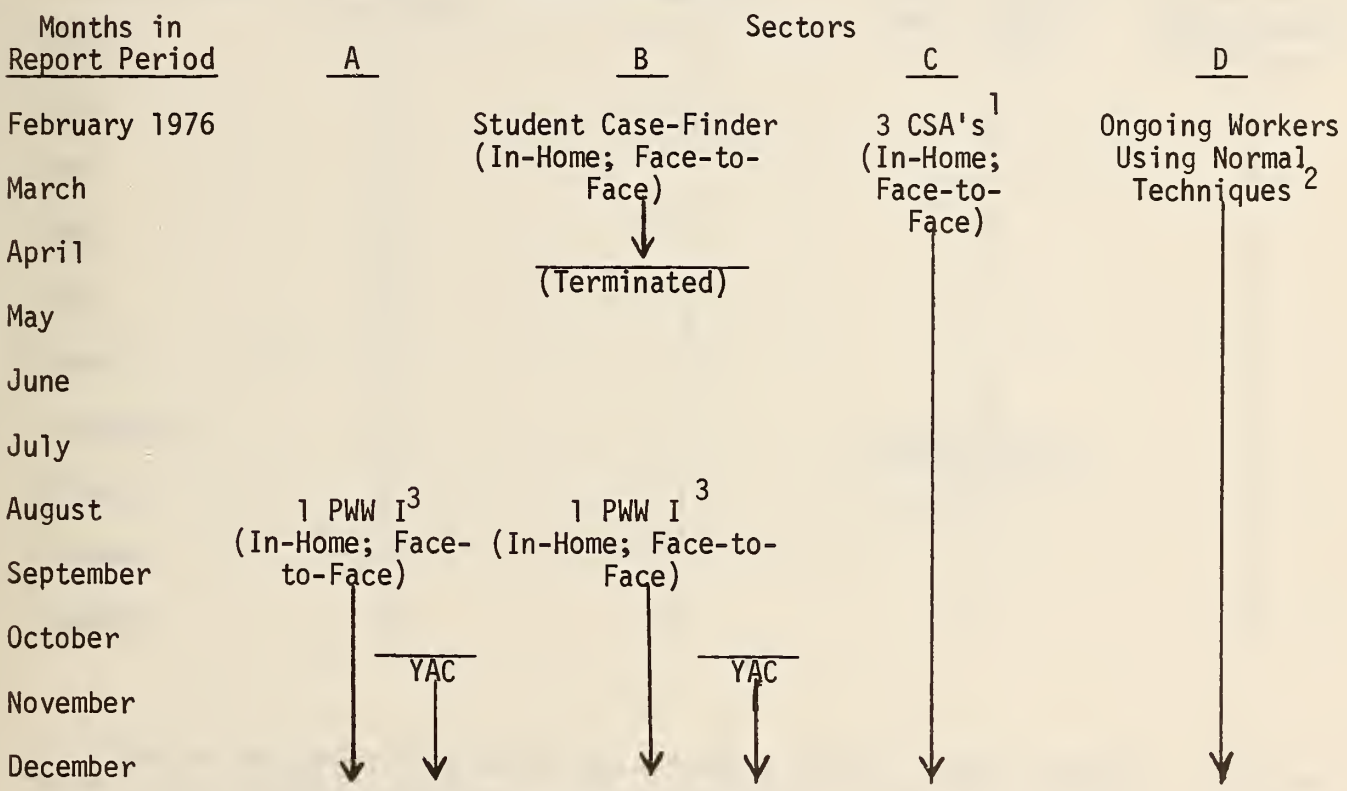
[3,4]This is a more or less constant total; an annual client turnover rate ("on" and "off" welfare eligibility) of 30% would adjust the total to 17,785 [3] and the project to 5,297 [4].

[5]Generally 95% black; 3% Spanish surname; 2% Anglo.

*First letter of last name.

De facto* schemata of these variables by sector for the period covered by this report are as follows:

CASE FINDING



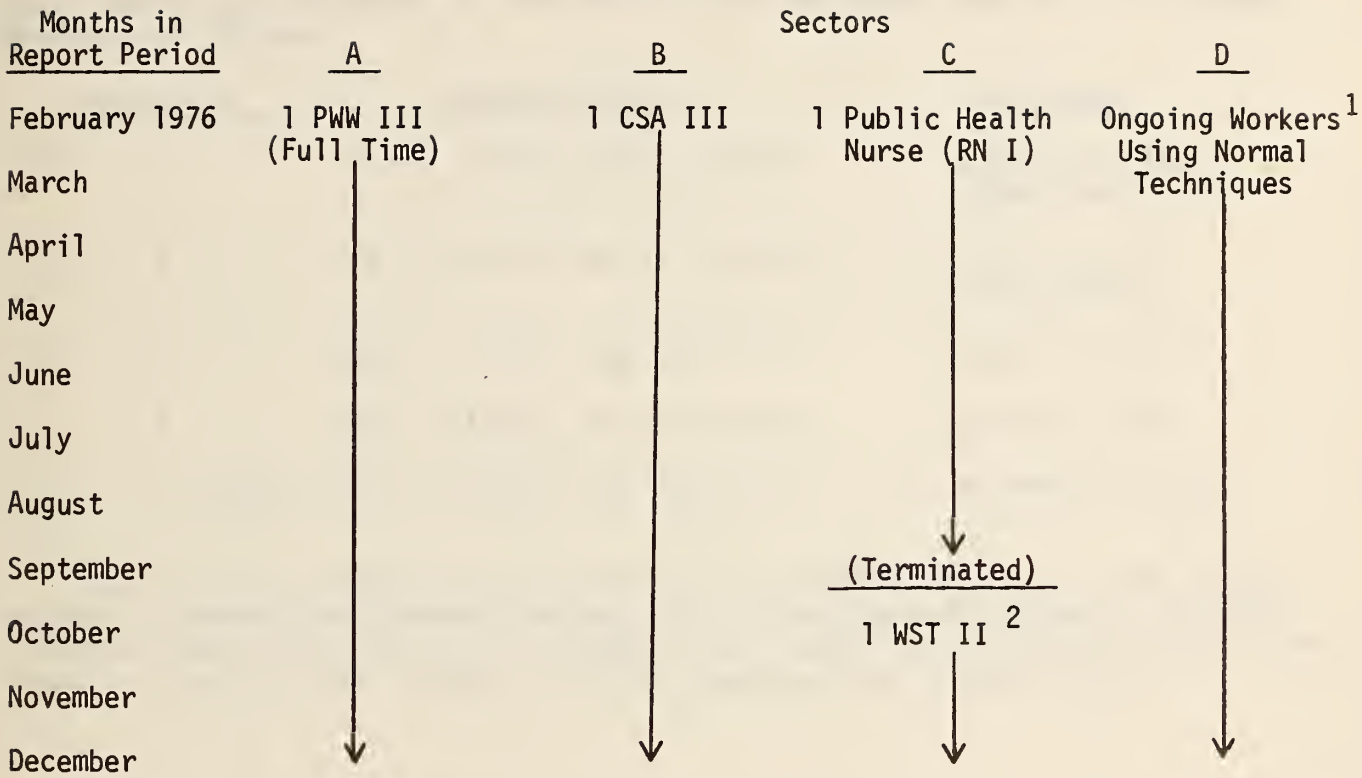
[1]Community Service Aides

[2]Worker time distribution: 30% letter contact; 20% telephone contact; 20% face-to-face contact (home visit and transportation). Remaining 30% to case monitoring.

[3]Public Welfare Worker I

*All schemata in this chapter and Chapters II and III following that relate to the evaluation of experimental variables are labelled "de facto". This is due to the fact that changes in variables and timing were most always dictated by circumstances, often outside the control of the project and the evaluator. The major circumstances involved are discussed in the respective chapters and in Chapter VI, The Project in Perspective.

CASE MONITORING



Health education of clients was a feature of all client contacts. This was to be a nonevaluated objective. All workers in the project area with client contacts attended special health education classes.

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[1] On-going workers with combined case finding/case monitoring responsibilities (30% case monitoring).

[2] Welfare Service Technician.

Evaluation Reports

In terms of the current report requirements stipulated by SRS, five evaluation reports are projected for the project over the three years of its expected duration, as follows:

Report No.	Period Covered	Due Date
1	Feb. 1, 1976 - June 30, 1976	October 15, 1976 (Completed)
2	Feb. 1, 1976 - Dec. 31, 1976	April 15, 1977 (This Report)
3	Feb. 1, 1976 - June 30, 1977	October 15, 1977
4	Feb. 1, 1976 - Dec. 31, 1977	April 15, 1978
5 (Final)	Feb. 1, 1976 - June 30, 1978	December 31, 1978

As a format in general each report will be complete in itself. The project historical perspectives chapter and the data systems chapter, including the data collection forms, etc., will be included in each report to preclude some users from having to obtain earlier reports to fully comprehend the current one.

Chapter II

CASE FINDING

Test Objective

The major variable in case finding in this report period was to test full time case finders of different skill levels doing exclusively face-to-face contact with eligible clients through home visits.

Secondary efforts were concerned with testing: (1) student case finders (undergraduate social service majors requiring some field exposure for course credit) using face-to-face home contact being reimbursed at $3.00 per client contact showing for screen; and (2) specially designated young adult clinics (YAC) for EPSDT screening as a means of affording greater participation of this group in the program.

The two case finder categories (full time workers and students) were to be compared for cost and effectiveness with each other and with the ongoing (control) activities. The ongoing techniques were generally the use of a letter notice to eligible clients advising them of the EPSDT program and inviting their participation in the program (estimated to be 30% of the case workers' effort); telephone communication with those clients providing an affirmative response to arrange a screening appointment (estimated as 20% of the case workers' time); and in infrequent instances, direct, face-to-face contact with the client to make a screening appointment (10% of time); or arrange transportation from the home to the screening site and return (10% of time).[1]

The Young Adult Clinic was to be evaluated on its impact on the participation of teenagers (13 - 20) in the EPSDT program (penetration rate) on a before and after basis.

Schema for Project Case Finding Activities

The "de facto" schema for this case finding component of the project was as follows, for the period February - December, 1976:

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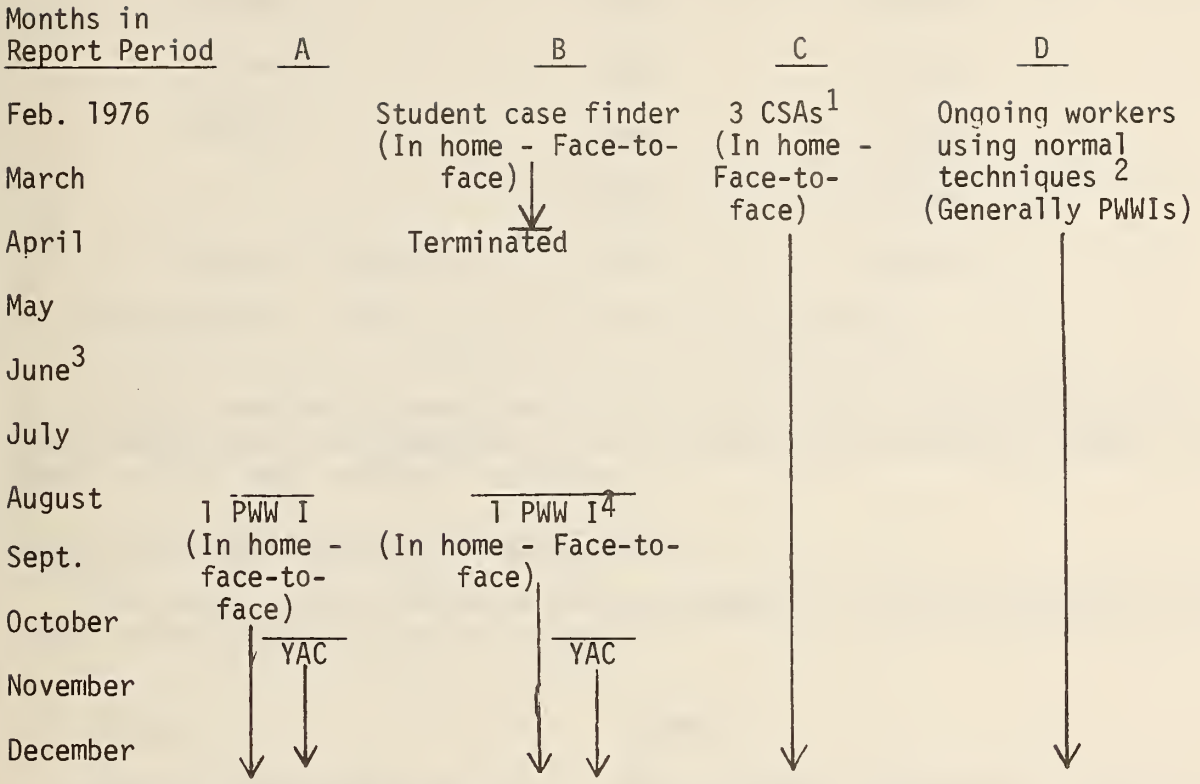
[1]The remaining 30% of case worker time effort is categorized as case monitoring (follow-up).

CASE FINDING



[1]Community Service Aides II

[2]Worker time distribution: 30% letter contact, 20% telephone contact; 20% face-to-face contact (home visit & transportation); remaining 30% to case monitoring.

[3]A new transportation contract was let on June 1, 1976 for the Dallas Region as a whole; therefore, effective that date, routine transportation support for Title XIX EPSDT eligibles again became available.

[4]Public Welfare Worker I

Program Eligibles (Target Population)

The target population (program eligibles) toward which these case finding activities are directed was approximately as follows on December 31, 1976:

	Approximate General Constant Population	Approximate Cumulative Annual Population[1]
Sector A	1,378	1,791
Sector B	1,280	1,664
Sector C	1,417	1,842
	4,075	5,297
Sector D (Control)	1,187	1,543

[1]Adjusted for a 30% turnover in welfare eligibility.

These represented approximately 40% of the total eligible population in the project area. The other 60% of the eligibles (approximately 8,400) are the clients of the "ongoing" activities.

Evaluation Effectiveness Measurement Rates

The rates to be utilized in the measurement of the effectiveness of these case finding activities are as follows:

Rate	Formula	
1. Rate of family contacts by type aide, by time (per week) Original contact Periodic rescreen contact	$\frac{\text{No. of family contacts by category of aide}}{\text{Weeks or months}}$	= Rate of contact per week or month by type aide
2. Rate of appointments made (of total eligible children in eligible families contacted)	$\frac{\text{No. first appointments made}}{\text{No. eligible children in families contacted}}$	= Rate of first appmts. made at end of 90-days, by type aide
3. Rate of appointments kept (of appointments made)	$\frac{\text{No. appointments kept}}{\text{No. appointments made}}$	= Rate of appmts. kept at end of 90 days, by type aide
4. Rate of shows for screening (Population penetration rate) Separate by age categories 0- 5; 6-12; 13-18; 19-20	$\frac{\text{No. of shows for screening (of denominator)}}{\text{No. eligibles (in sectors) on last day of report period}}$	= Rate of shows for screen (by sector) by technique being tested (by age group)

Evaluation of Variables

Following is the evaluation of the three case finding variables tested in this report period, i.e., (1) student case finders, (2) young adult clinics, and (3) full time case finders of differing skill levels employing face-to-face contact in home visits.

1. Student Case Finders

This variable was reported upon in depth in the Phase I evaluation report. In summary, 13 undergraduate college students (social service majors requiring some field exposure for course credit) were recruited from local universities and employed as EPSDT case finders. Representing the Department of Public Welfare, students made home visits to eligible clients, informed them of opportunities to obtain free physical examinations for family members under 21 years of age and appointed them to an EPSDT screening clinic. Students were paid $3.00 for each client whom they successfully appointed and who, as a result, received a medical screen at one of the several Department of Public Health screening clinics in the area.

This variable was utilized for the first three months of the project and terminated because of difficulties with a multi-level supervisory responsibility for administering the students and their activities. Notwithstanding the short duration of the testing period, a detailed special study (enclosure 1, Phase I Report) concluded that this type adjunct to regular EPSDT case finding activities had cost effective potential in certain urban areas and warranted further exploration under different circumstances.

The accomplishments of these students are identified in many of the tables reflecting case finding activities of the project during this report period.

2. Young Adult Clinics

The Young Adult Clinics were programmed too late and too infrequently in this report period to anticipate any real impact on the penetration rate of the 13 - 20 year eligible population. This variable will be more validly evaluated in the Phase III Report.

The intent of the Young Adult Clinic is to offer an extensive program of supplemental services that would interest young people (teenagers) at an EPSDT screening clinic. The hypothesis is that this type program would increase the participation of teenagers in the EPSDT program.

The project has contacted a wide range of service agencies in the Dallas area and has solicited their participation in the Young Adult Clinics. Following is a brief discussion of ten agencies that offer services at the Young Adult Clinics.

1. Al-Ateen offers assistance to young adults who find it difficult to deal with alcoholic relatives. This one-to-one teen-buddy system, under adult supervision, is a service branch of Alcoholics Anonymous.

2. CoCARE (Dallas County Mental Health and Mental Retardation Association) offers assistance through counseling to help interpersonal, personal, drug and alcohol-related problems.

3. Dallas City Dental Health Education Program offers dental care demonstrations, information about brushing and flossing, and information on how often to see a dentist.

4. Dallas City Nutrition Program offers help with diet assessment, weight problems, diet problems, and diet-connected medical problems.

5. Educational Opportunity Center (EOC) of the Dallas County Community College District offers counseling and assistance in applying for vocational or college grants.

6. Expanded Nutrition Program, working with the Dallas City Nutrition Program, offers the service of nutrition aides in the home, food buying and preparation, and diet counseling for pregnant women or women with newborns.

7. Family Planning, a service of the University of Texas (at Dallas) Health Science Center, offers counseling, education, male/female birth control methods, pelvic exams, Pap smear tests, and pregnancy tests.

8. Hope Cottage offers counseling for single parents, for childhood behavior problems, guidance sessions on how to be a good parent, and foster care services.

9. Texas Employment Commission offers information about job placement, the Job Corps, the labor market, training programs, unemployment insurance and apprentice programs. Job and career counseling also is available.

10. VD Control (Dallas City Health Department) offers counseling and education; pelvic physical exams for hernia, tumor, etc., and confidential VD exams.

Three Young Adult Clinics were held during the latter part of the report period with "show rates" of those appointed ranging from 34% to 39% and participation of from 15 to 40 teenagers.

One of the major concerns voiced by the agencies represented was the low number of clients attending the clinics. For some, this was not cost-effective utilization of their time. However, it was felt the concept is worthwhile and that if client participation could be increased then interagency participation would be extremely important and valid. The structure of the Young Adult

Clinics was reconsidered through discussion with each agency director during December 1976.

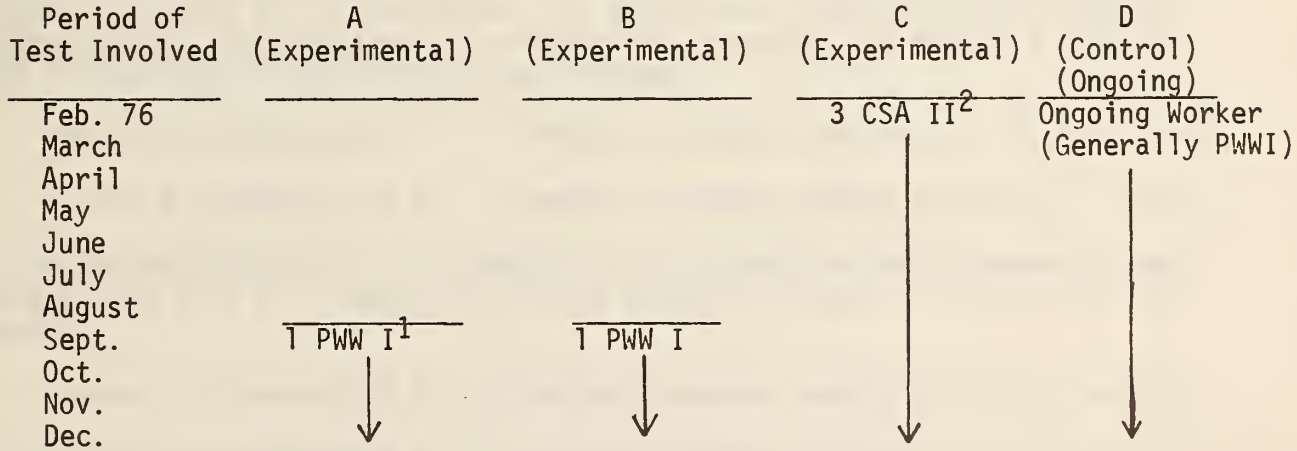
Agencies continuing to participate in the Young Adult Clinic have prepared written objectives and have identified ways to individually assist in the outreach effort. Changes in process or procedure developed prior to the January clinic will remain as a constant through the remainder of this demonstration. This will assure six months of consistent and valid collection of data regarding penetration rates, and problem referral/case completion rates specific to this client age group.

3. Full Time Case Finders of Differing Skill Levels Employing In-Home/Face-to-Face Contact

a. General

As indicated earlier, this is the major programmed activity of this project in the case finding subsystem. The objective is to test full time case finders of differing skill levels, all using the same client contact technique of in-the-home/face-to-face contact and compare each with the other and with the ongoing program to determine which is the most effective and cost beneficial.

The de facto schema for this evaluation is as follows:



[1]Public Welfare Worker I

[2]Community Service Aides II

b. Skill Levels

As is evident from the schema above, the skill levels of case finders being compared are the (1) community service aides and (2) public welfare workers I. The general criteria for these skill levels are as follows:

Community Service Aide II - This category of worker is generally indigenous to the project area. The job classification requires a minimum of a high school education and the salary level is in the range of $6,624 - $8,352 per annum.

Public Welfare Worker I - This category of worker is generally not indigenous to the project area. The job classification requires a minimum of a college degree (16 years) and the salary level is in the range of $9,840 - $12,408 per annum.

The skill level hypothesis is basically whether a worker (CSA) of a lower educational background (with a concomitant lower job classification and remuneration), but with closer "identification" with the client population, can be as successful in persuading clients to participate in the EPSDT program as a worker (PWW I) of a higher educational background (with a concomitant higher job classification and remuneration) and generally non-indigenous to the target population living area.

c. Client Contact Technique

Both categories of workers operate under the same methodology of client contact, i.e., in-the-home/face-to-face.

Both categories of workers function under the same direct services supervisor. The workers are assigned cases for client contact by the supervisor from the Texas State Department of Public Welfare MP 708, monthly list of current program eligibles by zip zone area. In the case of Sectors A and B, (which encompass four zip zone areas) in which single workers are employed (PWW I), each is assigned eligible clients as follows:

Sector A--Alphabetical A - J[1], Medicaid numbers ending with 3, 5, 7 and 9.

Sector B--Alphabetical K - Z, Medicaid numbers ending with 3, 5, 7 and 9.

In the instance of Sector C (a single zip zone area) in which several workers are employed (CSA II), each is assigned eligible clients as follows (if two workers):

Sector C--Alphabetical A - J, Medicaid numbers ending in 3, 5, 7 and 9.

Sector C--Alphabetical K - Z, Medicaid numbers ending in 3, 5, 7 and 9.

If three workers are assigned, a three way alphabetical division is made.

Workers are instructed to attempt to work their sectors by sub-geographical area, in order to conserve travel time.

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[1]Encompasses the four zip zone areas of 75203, 75208, 75216, and 75224.

Once workers have identified their specific target population, they again refer to the monthly roster (the MP708) which, in addition to other information, indicates the last screening date, if any, for each eligible person. Anyone without a screening date on the roster or whose last date is over 12 months old is eligible to be screened.

Clients selected for case finding for the EPSDT program are generally notified by letter by the case finder of the intent to visit the home on a specific date to discuss the program. Letters are generally mailed five to seven days in advance of the visit. The client is requested to advise the case finder by telephone if the visit is not convenient. If no negative feedback is received the case finders visit the home. The worker discusses the EPSDT program, the Texas Title XIX dental program[1], and family planning services available. Each visit takes approximately 25 - 35 minutes and the worker distribution of time to each of the three programs is generally as follows: EPSDT - 60%; dental program - 30%; family planning - 10%.

If the client indicates willingness to participate in the program, and has a phone, the case finder immediately calls for and makes a specific screening appointment on a day convenient to the client. If the client does not have a phone, he asks the client to indicate convenient dates and upon return to the office, makes the appointment and advises the client by letter of the appointment.

The case finders prepare and submit EPSDT Family Contact Forms (Form T-405), an example of which is contained in Appendix 1 to Chapter V of this report, for all contacts made.

In any event (with or without a telephone in the home), a reminder letter is sent just prior to the screening date to advise the client of the clinic location, date and time.

If, during the visit, the client indicates a need for transportation to the screening site, on the day before the clinic the worker notifies the transportation provider of the names, number and addresses of persons in need of the service.

After the clinic the worker determines which clients kept their appointments. The case finder receives results of the screening for children with no identified medical problems, then forwards the screening form to the responsible adult. Referral forms with suspected medical problems are sent to the case monitor. The case finder's work is completed for each client when the appointment is kept.

If the client misses the clinic appointment, the worker sends a letter, then phones the client or makes a return visit in an attempt to get the client to the clinic. The established system requires the case finder to attempt no

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[1]In Texas the dental equivalent of EPSDT is a separate program.

less than three clinic appointments to achieve a success. It is only after three unsuccessful appointments, or the expiration of 90 days, that the worker is permitted to drop the case as unappointable.

If, at the time of the initial home visit, the client failed to be at home, three repeated letter attempts are made to schedule another home visit. If no affirmative response is received to the first two, the third letter advises that services will continue to be available, if the client cares to contact the worker. Nevertheless, workers may, at their discretion, recontact these cases at any time prior to the next periodic sequence.

4. Evaluation of PWW I's and CSA II's as Case Finders (differing skill level - same technique)

Factors discussed in Chapter VI in the historical perspectives of the project indicate variations were made through necessity in the original research design. In the original design, two different categories of workers testing the same case finding technique (in-the-home/face-to-face client contact) would have operated parallel in the same time periods. The "de facto" design, however, had them initiating operations six months apart. The problem in evaluation is whether to compare (1) the first five or six months of activity for each, i.e., February - June for CSA II's versus August - December for the PWW I's (who did not initiate activity until August) or (2) the parallel five/six months for each, i.e., August - December. This choice is most difficult for a number of reasons. One, and probably the paramount consideration, is that operationally it became apparent that, as the case finding effort succeeded and increasingly higher percentages of client families were contacted, the contact of the remaining group became more time consuming. This was due to the greater distances involved in traveling between home locations of the smaller residual group, and to the fact that part of this group were also families with whom previous case finding efforts had failed (parent(s) work, etc.) The extent to which this factor could be "operable" in the situation is represented by the fact that, as of December 31, 1976, only 25% of the families in the sectors being worked by the PWW I's had been contacted, whereas in the sector being worked by the CSA II's, 80% of the families had been contacted. Since it is obvious that the CSA II's were operating under more difficult conditions (greater time requirements per successful contact; therefore greater costs per contact) during the latter five months (August - December), it was determined that the first five months of activity for each group (February - June, CSA II's; August - December, PWW I's) would be more representative of the parallel situation. Yet even this "preferred" solution has its limitations in that, for one, April was a uniquely uncertain month for the project (reference Chapter VI) and activity in that month was quite depressed. Two, DPW contract-provided transportation for clients to screening was not available from February through May. And three, the CSA II's placed a uniquely high concentration of case finding effort (48% of contacts) in this time period (February - June) on rescreens, who they apparently thought would participate in the program with less commitment of effort, and yet, in the final analysis, on the factor of "kept" appointments, were less likely to keep their screening appointments than original

contacts at the rate of 53% to 62%. On the other hand, the PWW I's only committed 4% of their effort to contacting rescreens; therefore, the PWW I's were certain to have a greater number of kept appointments from a given number of contacts since both had essentially the same rate of appointments made of those children in families willing to participate (98/99%).

At some point, however, the data must be allowed to "speak" for itself with all major variables identified. The major variables, as a judgment decision, favored the choice of comparison of the first five months of activity for each category of worker. The analysis that follows will be based upon this premise.

a. Contact Activity Comparisons

(1) Rate of Contact of Eligible Families (Of those eligible as of 12/31/76)

Sector A & B (PWW I's)		Sector C (CSA II's)	
No. of Eligible Families (On 12/31/76)	% Contacted (Thru 12/31/76) (Of eligibles)	No. of Eligible Families (On 12/31/76)	% Contacted (Thru 12/31/76) (Of eligibles)
1,050	25% (261)	559	80% (449)

Discussion:

The high density of contacts in Sector C is a result of a six month longer period of activity for the CSA's (February - July) and their relatively larger numbers (average of 2.6 full time equivalents to 1.92 PWW I's).

Notwithstanding, the high rate of contacts per eligibles in Sector C by the CSA's is unique in itself and, coupled with the other data in this report, discloses some important characteristics of the client population which has potential national program impact. These characteristics are discussed in detail under the heading of "appointments made", "appointments kept", and "penetration rates" of this chapter.

(2) Family Contact Activity

The distribution of contact effort by case finders between eligible families not previously participating in the program (original contacts)[1] and those previously participating and scheduled for a periodic screen (rescreen) was as follows:

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[1]Over time this category will include an increasingly large group of clients previously contacted in an earlier periodic sequence who did not participate either through direct refusal (unwilling to participate) or indirect (three or more appointment failures).

Distribution of Contact Effort by Two Categories of Case Finders Between Original Screens & Rescreens

	Overall		Original Contact		Rescreen Contact	
	No.	%	No.	%	No.	%
	PWW I's					
Feb-Mar						
Apr-Jun						
Jul-Sep	115	(100%)	108	(94%)	7	(6%)
Oct-Dec	137	(100%)	135	(99%)	2	(1%)
Total (6 Mo. - Jul-Dec)	252	(100%)	243	(96%)	9	(4%)
	CSA II's					
Feb-Mar	164	(100%)	86	(52%)	78	(48%)
Apr-Jun	210	(100%)	109	(52%)	101	(48%)
Jul-Sep	107	(100%)	71	(66%)	36	(34%)
Oct-Dec	138	(100%)	105	(76%)	33	(24%)
Total (11 Mo.)	619	(100%)	371	(60%)	248	(40%)
Total (6 Mo.-Jul-Dec)	245	(100%)	176	(72%)	69	(28%)

Discussion:

This table indicates that the CSA II's initially committed (February - June) 48% of their contact efforts on recruiting for rescreens. In the period of July - December, when it was possible to compare the activities of the CSA II's and PWW I's, they spent 28% of their contact efforts recruiting eligible clients for periodic EPSDT screens (rescreens), and the PWW I's 4%.

This initial tendency toward a high priority of effort for recruiting rescreens on the part of individual case finders (CSA II's) was discussed with the Direct Services Supervisor and Project Director in August. This same phenomenon was also occuring in the "ongoing" program and the State EPSDT Program Manager issued a "guidance letter" to State personnel suggesting that no more than 20% of worker case finding effort be expended for rescreens at this point in the EPSDT program development.

The reason for this worker priority toward a high concentration of effort on the rescreen group has not been substantiated, though it is surmised that they "felt" they could obtain credit for an "appointed client" with a lesser commitment of time and a higher degree of probability of an "appointment" success. Such an assumption, on the surface, has merit in that in a very real sense, this category of clients is already in the EPSDT system. There would seem to be some "hard data" to support this premise in that 94% of those clients due for periodic screens indicate a "willingness to participate" in the program, whereas only 87.5% of original contacts indicate such a willingness. It is postulated, however, that this difference is in a much lower order of magnitude than the workers had "assumed". Additionally, from an overall program view, even this hard difference is somewhat negated by the "kept appointment" rates for the respective group, with the periodic rescreens keeping only 53% of appointments compared to 62% for the original screen group (see discussion following of appointments made and kept). The assumed advantage in time commitment by concentrating on the rescreens also appears to disappear under close scrutiny in that in the first six months of CSA II activity (table following) in which there was a 48% concentration on rescreens, they achieved a monthly average of 25 contacts per FTE which is virtually the same contact rate (26) as the PWW I's in their first five months of activity in which they reflect only a 4% rescreen effort.

As indicated, the Direct Services Supervisor began to channel the CSA II case finding activity toward greater emphasis on original screens. With this direction, it is likely that the CSA II activity toward original screens would have been higher than the 72% indicated in the table for the average of the six months of July through December, except that the number of new eligibles (not previously screened) in Sector C was shrinking considerably as a result of the overall intense case finding action in that Sector.

In the overall, the data suggests that there is no advantage in time commitment per worker or probability of success in appointments made and kept by priority to rescreens over original screens. It would appear, at this stage of early development of the EPSDT program, that the appropriate balance of case finding effort should be in accordance with the actual distribution of these categories as components of the total group of eligibles, e.g., if previous contacts (screened) are 30% of the eligibles and non-screened are 70%, then the distribution of case finding efforts should be approximately in the order of 30% and 70%, respectively.

(3) Family Contact Activity by FTE[1] for each Category of Aide (Sector)

The full time equivalent effort of PWW I's and CSA II's in terms of family contacts, by month, was as follows:

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[1]Full Time Equivalent

Family Contacts by Type Case Finder (FTE), By Month

Month	PWW I's			CSA II's		
	No. Contacts	FTE's	Contacts per FTE	No. Contacts	FTE's	Contacts per FTE
Feb				94	3.0	31.3
Mar				70	2.4	29.2
Apr				32	2.3	13.9
May				88	3.0	29.3
June				90	3.0	30.0
5 Mo. Total (Feb-Jun)				374		
Average (1 Month)				74.8	2.74	27.3
Jul				38	3.0	12.7
Aug	47	1.6	29.4	17	2.0	8.5
Sep	68	2.0	34.0	52	3.0	17.3
Oct	56	2.0	28.0	57	3.0	19.0
Nov	37	2.0	18.5	57	2.0	28.5
Dec	44	2.0	22.0	24	2.0	12.0
5 Mo. Total (Aug-Dec)	252			207		
Average (1 Month)	50.4	1.92	26.25	41.4	2.4	17.25

These data produce the following work load analysis:

	PWW I's	CSA II's
Average family contacts per month	50.4	41.4
Average family contacts per week (4.35 wks. per month)	11.6	9.5
Average family contacts per day (5 days per week)	2.3	1.9
Average family contacts per week, per FTE	6.0[1]	4.0[2]
Average family contacts per day , per FTE	1.2	.8

[1] 11.6 family contacts per week ÷ 1.92 average FTE's = 6.0

[2] 9.5 family contacts per week ÷ 2.4 average FTE's = 4.0

Discussion:

Though the comparison of the last five months' activity for both categories (August - December) indicates a greater rate of contacts per time unit and full time equivalent for the PWW I's (26.25 contacts per FTE per month, as contrasted to 17.25 for the CSA II's), this difference is considered due to the changing nature of the tasks for the CSA II's. The previous table indicates that the CSA II's have contacted up to 80% of its eligibles, whereas the PWW I's have achieved an eligible contact rate of only 25%. The Direct Services Supervisor of both categories of workers has indicated that the "deeper" the case finders penetrate their eligible groups, the more complex the task becomes, due to the geographical spread of the remaining uncontacted and the increasing difficulties in achieving a successful contact (the client being at home to keep an appointment with the case finder). This premise is perhaps validated by the fact that if the first five months of the CSA's activities (February - June) are compared with the first five months of the PWW I's activities (August - December), average contacts per FTE per month are almost identically the same, i.e., 27.3 (CSA II's) and 26.25 (PWW I's).

Conclusion:

A conclusion that may be drawn from this analysis is that as the contact rate of eligibles increases over time, the more difficult and time consuming the contact effort becomes.

It is further concluded that from the comparison of the first five months activity for each category of worker, there is little difference in performance but because of the lower pay rate for the CSA II's, there is a $8.61 cost differential per family contact, i.e.,

	PWW I (Aug-Dec)		CSA II (Feb-Jun)	
	Rate	Cost	Rate	Cost
Family Contact per FTE	26.25 (per mo.)	$51.23 (per contact)	27.30 (per mo.)	$42.62 (per contact)

b. Appointment Activity Comparisons

(1) Rate of Appointments Made

(See table, following page)

Family Contacts, Children Represented & Appointments Made, by Two Categories of Case Finders

Time Period	1 No. of Family Contacts	2 No. Children Represented by Family	3 No. Families Willing to Participate in EPSDT	4 Children Represented by Families in Col. 3	5 No. Appts. Made for Children Participating	6 Rate of Appts. Made of Those Willing	7 Rate of Appts. Made of Those Contacted
			PWW I's (Sectors A and B)				
Feb - Jul	/	/	/	/	/	/	/
Aug	47	118	36	98	98	100%	83%
Sep	68	193	60	172	171	99%	89%
Oct	56	156	49	139	131	94%	84%
Nov	37	97	33	87	85	98%	88%
Dec	44	136	40	128	128	100%	94%
5 Mo. Total	252	700	218	624	613	98%	88%
			CSA II's (Sector C)				
Feb	94	260	78	204	202	99%	78%
Mar	70	173	64	160	159	99%	92%
Apr	32	73	24	57	56	98%	77%
May	88	230	68	190	187	98%	81%
Jun	90	248	74	209	208	99%	84%
5 Mo Total (Feb-Jun)	374	984	308	820	812	99%	83%
Jul	38	93	32	81	80	99%	86%
Aug	17	43	15	39	39	100%	91%
Sep	52	129	44	108	103	95%	80%
Oct	57	138	54	130	129	99%	94%
Nov	57	160	53	154	147	95%	92%
Dec	24	57	23	55	55	100%	97%
11 Mo. Total	619	1,604	529	1,387	1,365	98%	85%

Discussion:

This table is intended to represent the extent to which the respective categories of case finders are successful in "selling" the EPSDT program to the eligible clients. It appears that the PWW I's have a slight advantage in this regard, during the first five months of activity for each category of worker, in that they appoint 88% of children in families willing to participate, whereas the CSA II's appoint 83%.

Family Participation Rate

Two hundred and eighteen of 252 families, or 87%, of families contacted by the PWW's in the five month period of August - December were apparently persuaded to participate in the EPSDT program. Similarly, for the period of February - June, 308 of 374 families, or 82% of families contacted by the CSA II's were willing to participate in the program. This factor then indicates a somewhat higher performance effectiveness for the PWW I's.

Children Appointment Rates for Screening

In terms of "child" participation, the PWW I's achieved an appointment rate of those willing to participate of 98% and, of those contacted, 88%.

The CSA II's, similarly, for the same five month period of February - June achieved an appointment rate of those willing to participate of 99% and of those contacted, 83%.

Conclusion:

When these data are converted to average contacts per month per average FTE available for the respective time periods, the following emerges:

	PWW I (Aug-Dec)		CSA II (Feb-Jun)	
	Rate	Cost	Rate	Cost
Child Contact per FTE	73.0 (per Mo.)	$18.08 (per contact)	70.5 (per Mo.)	$17.74 (per contact)

This analysis indicates a slight edge in performance effectiveness for the PWW I's which, when compared with family contacts, results primarily from a small percentage of larger numbers of children in families contacted by PWW I's (2.78) than in those contacted by CSA II's (2.63).

(2) Rate of Appointments Kept

Number & Rate of Screening Appointments Made & Kept as Related to Two categories of Case Finders

Time Period	1 Number First Appointments Made	2 Number First Appointments Kept	3 Rate of First Appointments Kept (2 ÷ 1 = 3)
	PWW I's (Sectors A and B)		
Feb - Jul	/	/	/
Aug	98	37	38%
Sep	171	85	50%
Oct	131	53	41%
Nov	85	47	55%
Dec	128	50	39%
5 Mo. Total	613	272	44%
	CSA II's (Sector C)		
Feb	202	84	42%
Mar	159	61	38%
Apr	56	18	32%
May	187	68	36%
Jun	208	27	13%
5 Mo. Total (Feb-Jun)	812	258	32%
Jul	80	20	25%
Aug	39	11	28%
Sep	103	39	38%
Oct	129	48	37%
Nov	147	60	41%
Dec	55	21	38%
11 Mo. Total	1,365	457	34%
Overall Total	1,978	729	37%

Discussion:

This table is intended to represent the extent to which the respective categories of case finders are successful in obtaining (ascertaining) the "real" commitment of the clients to the program by actually keeping a screening appointment (show for screen) as distinct from the preceeding table which simply reflected the "apparent" commitment (making an appointment). As indicated in this table, there is a significant difference between the "apparent" and "real" commitment.

Prior to discussing the specific performance factors relative to the PWW I's and the CSA II's, there is a far broader implication worthy of discussion in these data. Ninety-seven percent (97%) to 98% of these willing to participate in the program accepted appointments to screening, whereas only 37% of those appointed kept the appointment. This, in itself, is a significant factor in that it implies that the first commitment (willing to participate and be appointed) for a major element of the client population, 60% (97.5% - 37.0% = 60%), may not be reflective of the "true" intent. Constant case finding follow-up on those clients not keeping the first appointment has resulted in an additional 14% keeping a second appointment and another 3% keeping a third appointment. No additional appointment efforts are made to appoint beyond the third broken appointment at any periodic sequence. In toto, it seems that 55% (37.0 + 14 + 3.5 = 54.5%) of those accepting appointments may be considered to have a "true" interest in the program and that 43% only an apparent interest--or are simply not convinced of the value of the program. It appears[1] that the initial commitment of many clients (43% at least) to participate in the program may simply be an intent to appease or pacify the case finder. The client may see an overt rejection of the program being viewed by the case finder as an indication of non-cooperativeness, or even indifference toward her children. In these terms then, it appears easier to indicate a willingness to participate in the program and accept an appointment and then simply not keep the appointment. This, then, is a covert rejection of the program. When some clients find themselves being re-approached by the case finder to explain the appointment failure and then accept a second appointment, they will "acquiesce" to the continued "pressure" and accept and keep the second appointment. With other clients, the first appointment failure will have been justifiable and they will willingly accept the second appointment. With this as a rationale, it can be stated only that the "true" interest in the program is in the range of 37% to 55% of those contacted and indicating a willingness to participate in the program.

Conversely, it can be stated that 45% to 63% of the eligible population have no real interest in the program at this stage of the eligible population's cognizance of "preventive health". It is important to reiterate that this is after one of the most intense outreach efforts attempted--face-to-face/in-the-home contacts.

The real challenge to the EPSDT program managers, both at the National and

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[1]A survey of "no shows" for screening is in process by the project with the objective of identifying the "real" reasons for non-participation.

State levels, is in determining the degree of effort, if any at all, they are willing to underwrite to bring this extensive segment of the eligible population into the program.

In an overview sense, much more general preventive health education will have to be undertaken to make serious inroads into this group. This, based upon the current level of "preventive health concern" in the American public, will take years. What are the interim alternatives? What is their likelihood of success? What are their probable costs?

The interim alternatives in a voluntary program to bring high participation rates (higher penetration rates) are more extensive case finding efforts. One such effort would be to intensify the in-the-home/face-to-face contact to include "escorted" service from the home to the screening point and subsequent treatment sites, using program dedicated transportation. Another approach would be to concentrate on screening of school age children through the school system, a point of actual convergence and concentration of children wherein only parent consent[1] would be necessary to initiate the screen and implement the follow-up after required treatment. An all-out outreach effort to bring those families and children not otherwise successfully recruited for the program could be in-the-home screening, a technique tested by Dr. William K. Frankenburg and his associates at the University of Colorado Medical Center and the Denver Neighborhood Health Program.[2]

It is hypothesized that these increasingly intensifying outreach methods would increase the eligible population participation in the program to 80% - 90%.[3] The costs of such activities are largely unknown, but it would appear logical to assume an increasing cost for cases brought into the system.

A proposal has been made to test these alternative case finding methods in the Dallas project for FY 78 to ascertain their probable rates of effectiveness (penetration/participation) and respective costs.

Another concept being considered is to use the "acute care" episodes of the eligible population as case finding efforts, program this site as the child's "medical home", and subsequently schedule the child for a full evaluation (a health assessment more or less identical to an EPSDT screening). Unknown at this point would be the "true" participation rate of the client population in a preventive health assessment program mode. It might well be quite similar to that experienced in the Dallas project. An appropriate demonstration of this concept approach to ascertain probable results appears warranted.

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[1]To include family and child history data.

[2]Peter Dawson, Marlin Cohrs, Charles Eversole, William K. Frankenburg, and Monty L. Roth, "Cost Effectiveness of Screening Children in Housing Projects", American Journal of Public Health, December 1976, vol. 66, no. 12, pp. 1194-1196.

[3]Accepting that, in a voluntary system, 90% probably represents the highest degree of participation attainable.

PWW I - CSA II Performance Comparison

As already established, there was no significant difference in the performance rates between the PWW I's and the CSA II's in identifying the "apparent" interest of the clients in the program as evidenced by "appointments made", but there is a considerable difference in performance rate in terms of "true" intent as evidenced by the rates of "appointments kept". In this specific area covering the first five months of activity for each category of worker, the clients of the PWW I's kept 44% of first appointments and the clients of the CSA II's kept only 32% of their first appointments.

Part of this difference, as already discussed, may be considered due to the CSA II's concentration on "rescreens", 48%, as contrasted to the PWW I's at 4% for their first five months of activity. It appears that the CSA II's had expected the "rescreens" to be "easier" contacts for show for screening than the original screens, but in actuality, this had not turned out to be the case in that the rescreens as a category kept only 53% of first appointments, whereas the original screen group kept 62% of first appointments.

Notwithstanding, it may be assumed that a significant part of the difference in rates of show for screening (kept appointments) between the two categories of workers is attributable to the higher levels of education inherent to the classification of PWW I's which enable them to more completely explain the advantages of the program and convert a greater percentage of clients into the category of "true" intent.

Conclusion:

In the primary performance analysis factor of "shows for screen", the PWW I's achieved a better rate of performance at a lower unit cost than the CSA II's, and would indicate that the PWW I is the skill category of preference in case finding employing in-the-home/face-to-face contact, i.e.,

	PWW I (Aug-Dec)		CSA II (Feb-Jun)	
	Rate	Cost	Rate	Cost
Child - Show for Screen (Of appointed)	44%	$32.71 (per show)	32%	$37.66 (per show)

c. Eligible Population Program Participation Activity Comparisons

(1) Rate of Shows for Screening of Those Program Eligible

Projected (Annualized) Eligible Population Penetration Rate (Eligibles vs Shows for Screen) by Category of Case Finder, Sector, and Age Group

Sector & Casefinder Category	1 No. Eligibles on 12/31/76 (3, 5, 7, & 9's)	2 No. Eligibles (from Col 1) who "showed for screen" PWW I's (Aug-Dec 5/12 CSA II's (Feb-Dec 11/12	3 No. Projected to show at Feb-Dec or Aug-Dec Annualized Rate 12/12	4 Projected No. of shows per FTE per Annum	5 Projected Penetration Rate (Col. 3 ÷ Col 1 = Col. 5)	6 FTE to Eligible Population Ratio
			ALL AGES			
A&B (PWW I)	2,658	375	909	473[1]	34%	1/1384[3]
C (CSA II)	1,417	662	722	277[2]	51%	1/545[4]
			AGES 0 - 5			
A&B (PWW I)	962	136	326		34%	
C (CSA II)	470	223	243		52%	
			AGES 6 - 12			
A&B (PWW I)	894	144	346		39%	
C (CSA II)	555	265	289		52%	
			AGES 13 - 18			
A&B (PWW I)	650	84	201		31%	
C (CSA II)	331	153	167		50%	
			AGES 9 - 20			
A&B (PWW I)	152	15	36		24%	
C (CSA II)	61	21	23		38%	

[1] 909 ÷ 1.92 average FTE's = 473

[2] 722 ÷ 2.60 average FTE's = 277

[3] 2658 ÷ 1.92 FTE = 1 per 1384 eligibles (see description following)

[4] 1417 ÷ 2.60 FTE = 1 per 545 eligibles (see description following)

Discussion:

The higher penetration rate for the CSA II's indicated (51%) is exclusively a factor of the 2.54 greater worker to eligible population density.

Since other areas of analysis indicate a greater performance effectiveness for the PWW I's, it is appropriate to convert the penetration rate to category of worker to determine the costs and savings involved by the utilization of PWW I's.

It is still, however, important to keep in consideration the increasing time commitment (personnel commitment) required by case finders as the penetration rate (PR) increases. It is in this context that the following analysis must be somewhat mollified.

If PWW I's were utilized in Sector C, based upon their higher performance rates, they could have achieved the same penetration rate (51%) with 1.53 FTE's at an annual dollar savings in personnel of $2,449. The following table reflects these results.

	Dollars mid-range of Wage Classification	No. of FTE's Utilized or Required to Achieve 51% P.R.	Wage Cost per Annum per Category of Worker to Achieve 51% P.R.
PWW I	$11,124	1.53	17,019
CSA II	7,488	2.60	19,468

In this context this would be one PWW I per 926 eligibles to achieve a 51% penetration rate instead of one CSA II per 545 required (utilized) in Sector C.

In other terms of planning significance, a PWW I FTE to eligible population ratio of one to 1384 produces a 34% penetration rate but it would take one per 926 to increase the penetration rate to 51%. In terms of Sectors A and B, with an eligible population level of 2,658, this would mean the following differences in costs:

Population	PWW I FTEs Required for 34% PR	PWW I FTEs Required for 51% PR	Dollar Cost (mid-range) per PWW FTE per annum	Personnel Cost for 34% PR	Personnel Cost for 51% PR
2,658	1.92	2.87	$11,124	$21,358	$31,925

The personnel costs are 1.49 times greater to achieve a 1.50 increase in penetration rate from 34% to 51%, using the same case finding technique (in-the-home/face-to-face contact).

This, then, becomes a major decision consideration of program managers and program policy makers--what level of penetration is the program objective? It is in this context that decisions concerning dollars and resources for EPSDT must be made.

There is a "trade off" in any event, for there will be short range costs based primarily upon projected long range benefits from the program.

Conclusion

The summation of costs for PWW I's and CSA II's using the same case-finding technique for the three performance effectiveness indicators is as follows:

Performance Effectiveness Indicator	PWW I (Aug-Dec)	CSA II (Feb-Jun)
Case Finding Costs Per:		
1. Family contact per FTE	$51.23	$42.62
2. Child contact per FTE	18.08	17.74
3. Shows for screen	32.71	37.66

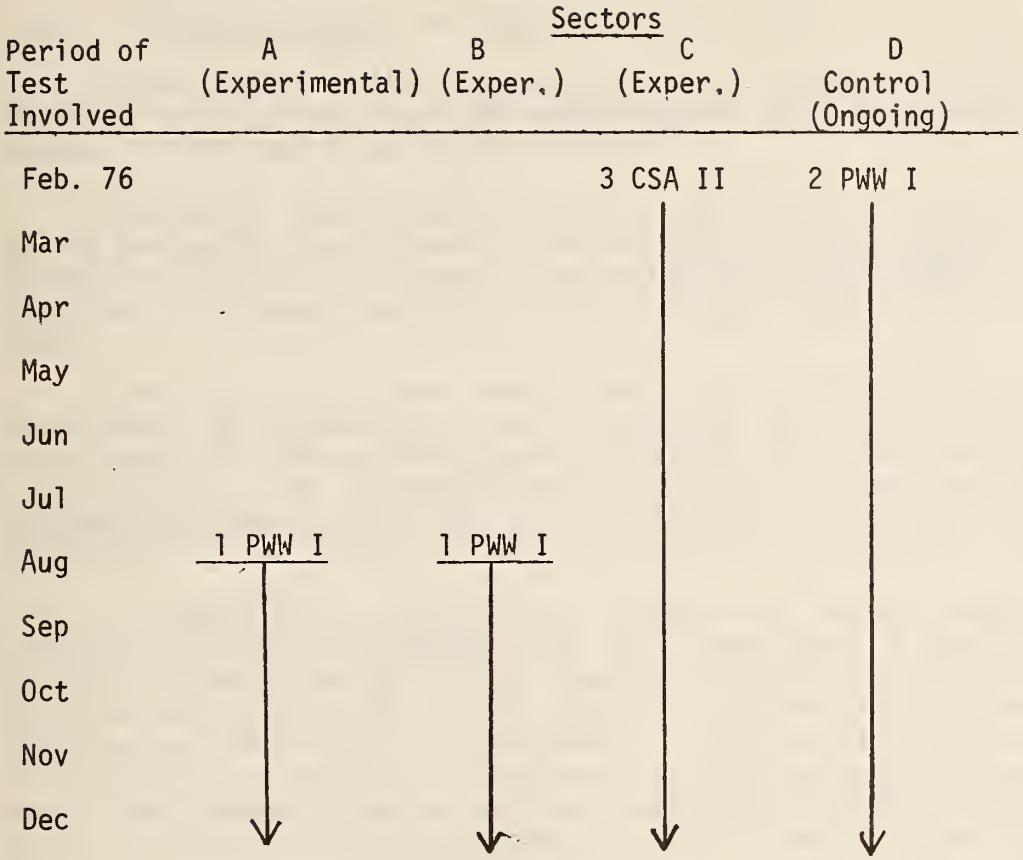
The PWW I's are more cost effective than CSA II's as case finders at designated levels of output, using the in-the-home/face-to-face technique.

d. Evaluation of PWW I's as Case Finders Employing Different Techniques (Experimental Sectors A & B compared to Control Sector D)

"Full confidence" in these results is somewhat restricted at this time because of the limited time frame (August - December) in which the PWW I's in both Sectors A and B were operable. These delays were linked to the difficulties in determining delineated roles for the "ongoing" and "project" activities that were fully discussed in the Phase I report (also see Chapter VI, this report, "The Project in Perspective").

A tentative evaluation of this variable based on preliminary data follows. As indicated, this is a comparison of the same skill level of persons performing case finding activities employing different techniques. This is a Sector A/B with Sector D comparison.

The de facto schema for this evaluation was as follows:



Skill Level (PWW I)

As earlier indicated, this job classification requires a minimum of a college degree (16 years education) and the salary level is in the range of $9,840 - $12,408 per annum. This category of worker is generally not indigenous to the project area.

Client Contact Technique

Sectors A & B

The technique in Sectors A and B is in-the-home/face-to-face contact. This technique is described in detail in the previous section of this report (pages 13 to 15). Case finding is the sole function of the workers involved (PWW I's).

Sector D

The technique employed by the two PWW I case finders in Sector D representing the control or ongoing type activity of the EPSDT program is generally letter notification to eligible clients concerning the program and telephone or letter follow-up to affirmative responses to set up screening appointments, arrange transportation, etc. The "ongoing" worker" is employed

both in the case finding and case monitoring roles.

The evaluation of the "control" (ongoing) is based upon data submitted for those clients with Medicaid numbers ending in 3, 5, 7, and 9, the 40% sample, in zip zone areas 75210 and 75223.

Time sheets, upon which cost data is predicated, are submitted weekly by the designated control sector workers. Project Data Sheets (Form T-406; example in Appendix 2, Chapter V) are prepared by data clerks at the screening site for all clients from Sector D with Medicaid numbers ending in 3, 5, 7, and 9.

A special study of the "Control Sector" involving structure, organization, definitions and methodologies was accomplished by this Institute's on-site coordinator, Ms. Nancy Barbas, and is included with this report as Enclosure 1 for reference. The techniques employed by the "ongoing" case workers in the outreach function to which 60% to 70%[1] of their working time is committed, are as follows:

1. Selects cases for outreach. Each worker selects cases from his/her assigned case load as defined by the unit supervisor. A list of eligibles in a unit's jurisdiction (MP 708) is supplied by the State Medical Services Division and is available to each worker. A worker selects approximately 20 families per week whom he will outreach. After eligibility, the major basis for selection is whether a client has ever received medical screening services and, if so, whether they are due for a periodic rescreen. Workers proceed and select clients as their names appear on the list, working down alphabetically.

2. Obtains case record. Workers obtain case records either at the time of case selection or not until a return response to a letter contact is made. Generally, if a worker intends to make intense outreach efforts, as described in 4(2) following, he/she will obtain client records upon sending a letter and keep them until the end of that intense effort.

3. Mails contact letter. Upon selection, a client is sent a letter by a worker with instructions for the client to call the worker, and perhaps giving a brief explanation of the EPSDT program.

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[1]Time sheets submitted by the ongoing workers for October and November, 1976 indicates 50% of time devoted to case finding; 47% to case monitoring; 3% to training and administration. This is a continually changing time proportional commitment. As indicated in the first evaluation report (page 7), prior to the project and introduction of a case follow-up system, the proportion of time devoted by ongoing workers to follow-up was approximately 10%. As the system was introduced, and at the time of the first evaluation report, the proportion had grown to approximately 30%. With the continued emphasis within the State, the introduction, State-wide, of the follow-up forms 402/402S, it appears that at the end of this second report period, the proportion has increased to approximately 50%. This may be its point of stabilization.

4. Phone response. Clients usually contact workers by phone in response to letters within five days of their mailing. If a client does not contact the worker, one of two treatments may occur: (1) The clients will be considered "returned to the pool" of eligibles and sent a letter again when the worker returns to his/her name after proceeding through the list of eligibles. This period of "lapsed outreach attempts" is estimated to be a maximum of two months. (2) The client will receive another letter by the end of the next week, and furthermore, continue to be outreached immediately until a response is attained or until the worker establishes that at least three letters were sent and a home visit made without success. Home visits are regularly made to those clients who do not respond to letters regardless of the timing of the letters.

5. Client contact. If a client requests services, appointment scheduling occurs immediately when the first direct communication between the worker and client takes place. This immediacy is facilitated by the fact that 85% or better of the direct communication is a result of a client's calling a worker in the office as response to a letter. The worker is able to determine a client's interest in participating and to call the clinic scheduling office (located at MLK Center) while the client simply holds the line. The client is also informed that a request for dental services will be initiated to Austin for those eligibles in the family who want the service. Furthermore, the worker inquires as to the need for transportation and will instruct a client in its use if desired during this first direct contact.

Those fewer instances in which a client/worker communication occurs at a home visit are handled in the same fashion as over the phone, though somewhat delayed due to the need to schedule and confirm appointments, often without immediate access to a phone. Clients who do not have phones receive appointment confirmations through the mail.

6. Follow-up to appointment setting. (Reminders and transportation arrangements.) The transportation system that exists places ride scheduling and organization within the responsibility of an EPSDT unit. In scheduling transportation to a clinic for a client, a worker must simply coordinate with the individual in the unit who is assigned transportation responsibility at that time. Transportation arrangements must be made at least 24 hours before an appointment. A van (available through contract with a private transportation company) runs more or less as a shuttle service to and from a clinic throughout the day according to the schedule coordinated through the unit's transportation worker. The transportation worker actually rides on the van the day of the clinic.

In addition to scheduling transportation, prior to the appointment day the worker sends a reminder letter to each scheduled client family. The worker plans client reception of the letter within three days before the clinic and will also often phone the client the day before or the day of the clinic.

7. Clinic attendance. A worker is informed of kept and missed appointments by the reception of clinic screening records (F400) for those who did show. The records are received from the screening team two to three weeks after the clinic.

Those clients who did not keep appointments (no F400) are contacted as soon as possible. Usually this is attempted by means of a letter of inquiry requesting the client to call the worker. The worker attempts to establish the reason for the unkept appointment and determines if the client is still interested in the services. In other words, once a client has expressed interest and been scheduled for one clinic appointment, an intense effort takes place to acquire a show at the clinic. Workers contact clients by letter or phone in attempts to reschedule appointments. Home visits are regularly made to those clients who do not respond to at least three letters or those clients who have been scheduled two to three times and continue to miss apointments. A home visit is often a last effort to achieve client participation. Workers often use their own judgment to determine a client's intentions and obstacles in keeping appointments and will base decision on when to close efforts on this. The unit's unwritten, though agreed upon, minimum level of effort is three missed appointments before closing a case.

8. Medical status. Those clients who keep clinic appointments are contacted appropriately, depending upon their status after the screen. If no referral is made, they are sent a letter of closure for medical services and the screening records. A case remains open though, if a client has been referred and/or has requested dental services.

e. Eligible Population Program Participation Activity Comparison

General

The only basis for comparison of the ongoing and demonstration activities in case finding is in terms of "shows for screen", full time equivalents of effort, and related costs. This is a reasonable, though limited, basis. The limitation is due to the totally different techniques utilized by both groups in contacting clients. As previously indicated, the demonstration workers concentrate on "in-the-home/face-to-face" contact, and the ongoing workers, a combination technique, primarily letter/telephone contact, with home visit on an exception basis. Additionally, the ongoing workers are committed to both case finding and case monitoring in the range of 50 - 70% case finding and 30 - 50% case monitoring, whereas the project workers are "full time" (100%) case finders or "full time" case monitors. The case finding documentation of contact efforts in the project are recorded on the Family Contact Card which was designed to record face-to-face contact techniques. The only data submitted by the control sector designated ongoing workers are "time sheets" to indicate time spent in case finding, case monitoring, etc., from which "full time equivalent" data are obtained. Shows for screening data are initiated by data clerks at screening sites for clients with Medicaid numbers ending in 3, 5, 7, and 9 from the project zip code areas in Sector D (75210 and 75223). Costs for the ongoing activities have been developed by the project administrative officers from time sheets, consultation with "ongoing" workers and supervisors, and extrapolation of project costs in some areas of indirect costs. Time sheets were initiated by control sector workers beginning in late October 1977.

Projected (Annualized) Eligible Population Penetration Rate: Eligibles vs Shows for Screen, by Two Similar Categories of Workers Using Different Case Finding Techniques

Sector (Technique)	1 No. Eligible on 12/31/76 (3, 5, 7, & 9's)	2 No. Eligible (from Col 1) who "showed for screen" Sector A&B; Aug-Dec 5/12 Sector D; Feb-Dec 11/12	3 No. Projected to "show" at Aug-Dec & Feb-Dec rate Annualized 12/12	4 Projected No. of shows per FTE per Annum	5 Projected Penetration Rate (Col. 3 ÷ Col. 1 = Col. 4)	6 FTE to Eligible Population Ratio
			ALL AGES			
A&B (In-home/Face-to-face Contact	2,658	379	909	473[1]	34%	1/1384[3]
D (Letter/ telephone)	1,187	464	506	421[2]	43%	1/989[4]
	3,845	843	1,415			
			AGES 0 - 5			
A & B	962	136	326		34%	
D	383	147	160		42%	
			AGES 6 - 12			
A & B	894	144	346		39%	
D	448	192	209		47%	
			AGES 13 - 18			
A & B	650	84	201		31%	
D	291	106	116		40%	
			AGES 19 - 20			
A & B	152	15	36		24%	
D	65	19	21		32%	

[1] 909 ÷ 1.92 FTE = 473

[2] 506 ÷ 1.20 average FTE = 421

[3] 2658 ÷ 1.92 FTE = 1384

[4] 1187 ÷ 1.2 FTE = 989 (1.2 FTE represents an average of 60% of time to case finding for 2 FTE--see narrative following)

Discussion:

This table indicates that the ongoing workers, using the letter/telephone technique, achieved a 43% penetration rate, whereas the project workers, using the in-the-home/face-to-face technique, achieved a 34% penetration rate.

From the data now available, there were 1.92 FTE project case finders and in the range of 1.4 to 1.0[1] full time equivalents for the ongoing activity.

There is a significant off-setting of the difference between the two penetration rates by the difference in ratio of worker to eligible population. Data from the previously discussed variable of skill level comparisons, using the same case finding technique, indicated that it would take one PWW I (FTE) per 1,384 eligibles to achieve a 34% penetration rate and one PWW I (FTE) per 545 eligibles to achieve a 51% penetration rate. A straightline extrapolation of these data indicate that it would take one PWW I (FTE) to 940 eligibles to achieve a 43% penetration rate, using the in-the-home/face-to-face technique. These data give a slightly higher performance effectiveness evaluation (5%) to the face-to-face technique over the letter/telephone and is reinforced by a (4%) cost advantage per show for screen in the table following.

It had been anticipated that performance effectiveness, as distinct from cost effectiveness, would have been much more significantly in favor of the highly personal in-the-home/face-to-face contact technique over the less personal letter/telephone technique. As previously discussed, however, there is a significant category of clients (approximately 40%) who, in the face-to-face situation, will express an intent to participate, but will miss as many as three appointments for screening and may be considered to have covertly rejected the program.

The letter/telephone approach soliciting an initial overt action to demonstrate program interest (a return telephone call or letter) may, by its nature, "sift out" the group that the project workers expend time and effort on, but who have no true interest in the program. The very nature of this premise, however, establishes a probable client participation ceiling in the area of 40 - 50%. As previously indicated in this paper, it becomes a policy level and program management decision to determine if the program will penetrate beyond the 40 - 50% point to bring the more difficult to recruit clients into the program, and, as otherwise discussed, to determine what techniques to employ and resources and dollars to commit to achieve the participation objectives established.

(2) Cost of "Shows for Screen"

The following table examines the relative cost of "shows for screen" of the two different categories of case finders.

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[1]Based upon a changing rate of time commitment of ongoing case workers from approximately 70% of their time to case finding at the beginning of the report period, to approximately 50% at the end of the period. A mid-point of 60% to case finding applied to two FTE workers yields 1.2 FTE for case finding.

Case Finding Costs per Show for Screen by PWW I's Employing Two Different Techniques

Time Period	Number Shows 1	Case Finding Costs 2	Dollar Costs per Show for Screen (Col.2 ÷ Col.1 =) 3
		Sectors A & B (In-home/Face-to-Face)	
Aug.-Sept.	176	$4,502[1]	$25.58
Oct.-Dec.	211	8,156	38.65
Total	387	12,658	32.71
		Sector D (Letter/Telephone/etc.)	
July-Sept.	159	- -[2]	--
Oct.-Dec.	135	5,451	40.38
Total	294		

[1]Cost data initiated generally on or about August 15 as representative of approximately six weeks rather than 13 weeks that would normally constitute a quarter.

[2]Time sheets and cost data for "ongoing" were not fully implemented until October, 1976.

Discussion:

The cost data in the above table pertaining to shows for screen are that incomplete prior to the October - December quarter as to restrict the use of the cost data to only that quarter (October - December). This short period of time to compare cost data lacks credibility but, on the surface, it appears that costs per show for screen at designated levels of client program participation (penetration rate) using the in-the-home, face-to-face technique is slightly more cost beneficial.

Conclusion

On the basis of preliminary data it appears that the case finding technique of letter/telephone contact employed by the ongoing program is proximally as cost effective as the face-to-face/in-the-home technique utilized in the project at designated penetration rates.

Chapter III

CASE MONITORING

Test Objective

The major variable in case monitoring in this report period was to test full time case monitors of different skill levels using the same technique to ascertain at what minimum skill the maximum rate of immunization completions, problem completions and case completions could best be achieved.

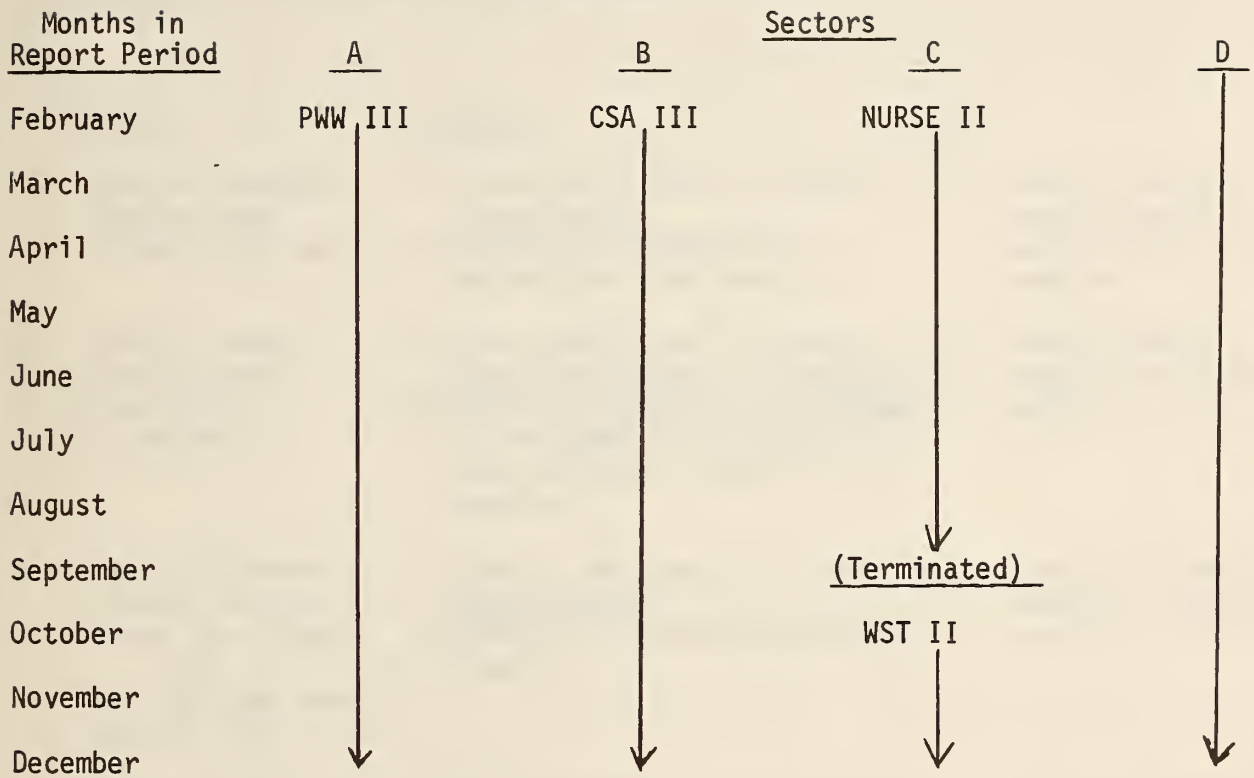
A subsequent comparison will be made between comparable skill levels of case monitors (PWW I's) in the experimental and control groups employing different techniques. A data base to support this objective was begun in May 1976 in the control sector (on going) when the State of Texas initiated its new case monitoring system in the Dallas area and began the use of the TDHR-DPW Form 402 and 402S(EPSDT Early Periodic Screening Diagnosis and Treatment - Medical Referral and EPSDT Medical Referral Supplement, respectively). The forms were adopted state-wide in December 1976. Essentially there is a different philosophy represented by the project case monitoring and on-going case monitoring. The project is attempting to demonstrate follow-up through treatment completion or other terminating resolution of the case or problem. The on-going activities are only endeavoring to trace children to treatment -- to "show for treatment". These are two significantly different objectives; the latter serving the legalistic aspect of the Federal penalty guidelines and the former anticipating a greater future demand for treatment comprehensiveness within the EPSDT program.

An on-site special study of the on-going results (Form 402 and 402 S) will be accomplished by sampling a group of children screened with problems found in the control sector to determine a rate of "show for treatment". These will be compared with the same rate for the "experimental group". Similarly, this same group will be further studied in reference to treatment provider records or parent supplied data to ascertain those children who "completed treatment" or whose cases were otherwise administratively terminated.

Schema for Current Case Monitoring Activities

The "de facto" schema for this case monitoring component of the project was as follows for the period February - December 1976:

Case Monitoring



This schema represents a comparison of Sectors A, B, & C each associated with special categories of workers employing the same technique for case/problem resolution.

Evaluation-Effectiveness Measurement Rates

The rates to be utilized in the measurement of the effectiveness of these case monitoring activities are as follows:

	Rate	Formula		
1.	Rate of Problem Completions (Single problem)	# Confirmed problems resolved (completed) / # Confirmed problems (by sector/type case monitor)	=	Rate of problem completions by sector/type case monitor
2.	Rate of Case Completions (Multiple problems)	# Case completions or resolutions (of cases in denominator)[1] / # Confirmed unwells (2 problems) (3 problems)(4 problems)(5 or more problems) (sector/type monitor)	=	Rate of case completions (sector/month)
3.	Rate of Screen Completions (of shows for screen) AND Periodic Rescreen Completions	# Screens completed (of shows in denominator) / # Shows for screen (sector/type aide)	=	Rate of screen completions (sector/month)
4.	Rate of Immunizations (current for age)	# Immunizations current for age at end of 150 days (for denom.) / # Immunizations not current for age at point of entry to initial visit (shows for screen)	=	Rate of immunizations completed (sector/month)

Sources of Data

Whereas, in original concept it was hoped that the project data on completions and resolutions would come primarily from the practitioner treating the children, the State (DPW/DHR) ruled that no contacts could be made by project workers with

[1] Generally all cases must be resolved in one form or another by the end of 180 days (180 days following problem sheet initiation).

physicians beyond any contact inherent to the new State sponsored 402/402S system (to show for treatment)[1]. This required the project to primarily base its data on completions and resolutions, such as the status of the problem (treatment completed, still under treatment, referred to other practitioner, etc.) on information obtained from mothers and children -- a less reliable source of data. This decision by the State was predicated upon a high level of sensitivity to the medical profession's possible unfavorable reaction to additional administrative requirements being associated with EPSDT in a time frame in which the State was introducing its new EPSDT forms (402/402S) statewide.

Evaluation of Variables

1. General

As indicated earlier, the major variable in this time frame in case monitoring was to test full time case monitors of different skill levels using generally the same case management techniques to ascertain at what minimum skill level the maximum rates of immunization and problem completion could best be achieved.

2. Skill Levels

A general description of the three skill categories is as follows:

Public Health Nurse (Nurse II)

The position requires a Registered Nurse. The salary range for this position is $12,000 to $15,108.

Social Worker (PWW III)

Qualifications for the position of Social Work Monitor included minimum education of a Bachelor's Degree, with a Master's Degree in Social Work or two years social service work experience. The salary range for this position is $11,232 to $14,148.

Case Monitor Aide (Community Service Aide III)

This position requires a high school education and at least one year experience in welfare/social service type work activity. Residence in the geographical project area is desired. The Aide attended the formal two week training course specific to EPSDT and the research project. The course was designed for individuals who lack social service and EPSDT experience. (Further detail on the course can be found in the manual "Training Program for Case Finders and Case Monitors in EPSDT" prepared by HSRI). The salary range for this position is $7,580 to $9,528.

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[1] A new case monitoring subsystem to the Texas EPSDT program.

An unprogrammed change occurred during the report period to introduce and test a fourth category of worker -- a Welfare Service Technician. This change is depicted in the schema for Case Monitoring Activities appearing earlier in this chapter.

The Welfare Service Technician position is intermediate to the PWW III and the CSA III.

The general description of this skill category is:

Welfare Service Technician II

The position requires the minimum of 60 hours (2 years) of college background. The salary range for this position is $9,840 to $12,780.

3. Case Monitoring Activities and Techniques

All categories of workers operate in three major activity areas under the same general methodology of case management.

Major Activity Areas

Case monitors execute follow-up in three major activity areas; i.e., medical condition referral, immunization referral, and dental service referral. A general definition of these respective activity areas is as follows:

A. Medical Condition Referral

Monitors assist clients in understanding the existance of a problem, in making appointments with appropriate medical providers for the duration of the problem, and in overcoming obstacles in keeping appointments for referrals originated by the Title XIX Screening Team.

B. Immunization Referral

Monitors assist clients in acquiring immunizations for children under seven years of age who were of incomplete immunization status according to guidelines of the Title XIX Team and the American Pediatrics Association.

C. Dental Service Referral

Monitors assist clients who are appropriately certified as program eligible in making the initial appointment with a dentist.[1] Monitoring responsibilities do not extend beyond the client's initial visit, though further treatment may be required and authorized.

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[1]The State of Texas Title XIX Dental Program is unique among the states. It is administered separately from the overall EPSDT program.

In approximate terms case monitors distribute their time at 55% to medical and immunization follow-up and 45% to dental service referral.

Case Monitoring Generalized Techniques

In the area of each activity the case monitor receives information concerning clients in his/her sector who have a requirement for follow-up activity. This notification consists of receipt of the following forms in the respective activity area:

A. Medical Condition Referral

Medical Referral forms 402 and/or 402S (from screening site)(example enclosed in the appendix to Chapter 5).

B. Immunization Referral

Immunization Annex, Project Form T-407 (from screening site)(example enclosed in the appendix to Chapter 5).

C. Dental Approval Card

Request for Dental Services Postcard (Form D101)(Approved: from Texas Department of Health). (This form would have been initiated by the case finder contacting the client. Upon return from the TDHR to the project unit, the Project Area's Supervisor [supervising both case finders and case monitors] would refer the card to the appropriate case monitor).

After receipt of the Medical Condition Referral (402/402S) indicated above the case monitor initiates an EPSDT Case Monitoring Sheet (Form T-408 [example enclosed in Appendix 2 to Chapter 5.]). This is a project designed form to constitute a case auditing/tracking sheet for the monitor until the case/problem is resolved or otherwise appropriately terminated.

The case monitor in all areas of activity attempts to initiate contact with the client to assist in the acquisition of the needed service; e.g., medical treatment, immunizations, dental treatment. Generally, if a client has a telephone, the monitor calls to arrange a time for a home visit and then makes the personal contact at the appointed time. Frequently a second confirming call is made the day prior to the appointment. In some instances, such as problems identified by laboratory tests, two to four weeks might elapse between screening and identification and initiation of a problem referral sheet. If a parent has already taken a child to treatment because of other developing symptoms, the case monitor is able to determine the resolution of the problem in the initial phone contact.

If the client does not have a phone, the case monitor advises the client by letter of the intent to visit the home at a specific date and time or asks the client to call in order to establish an appointment.

At the home visit the monitor explains the nature of the problem and then assists in arranging for a treatment appointment, with a practioner of the client's choice. Where transportation is needed the case monitor assists in arranging it.

Follow-up contacts are made by phone and subsequent home visits to determine whether the treatment appointment was kept. If not kept, subsequent appointments are made to a total of three.

Each case is kept active (under surveillance) by the respective case monitor for subsequent appointments and referrals if needed. The case remains active in the monitor's case load until one of the following situations occurs:

A. Medical treatment terminated by resource/treatment completion.

B. Family moved.

C. Family became ineligible.

D. Client refused to make appointments.

E. Six months lapsed since referral date and client was able to to continue seeking treatment on her own.

F. Monitor was unable to contact client after repeated attempts.

G. Client repeatedly missed appointments.

Both medical and immunization follow-up activities conformed quite generally to the procedures described above. Each follow-up (medical and immunization) was equally demanding in time and effort. Dental follow-up (monitoring) was generally confined to assuring that the client reached "initial" dental treatment.[1] As in the medical, three appointment attempts are made to achieve a successful "kept appointment". Under the Texas Title XIX Dental program, if treatment is required beyond this point the practitioner must submit a treatment plan for State approval. In the normal context of the EPSDT program (on-going), follow-up terminates with the initial sequence. The project also terminates follow-up at this point since dental follow-up beyond this was not included as a project objective.

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[1]This is a specific "packaged" pre-authorized ($30.00) dental screening and treatment procedure.

4. Evaluation of Three Skill Categories of Case Monitors Using a Common Technique

The system for executing case monitoring, just previously described, was developed and refined during this report period.

A comparison of the performance of the three categories of case monitors is hampered by the inadequate caseload that developed during the report period. This circumstance limits the use of the minimally available data to conduct an objective evaluation at this time.

The inadequate case load derived from, for one, the administratively reduced population of children to be involved in the project. In concept and proposal the project was to encompass approximately 13,000 children in the experimental sectors (A, B, & C) and 3,500 children in the control sector D. As indicated in Chapter VI, "The Project in Perspective", a change in organizational relationships necessitated a restructuring of the eligible population so that for a period of several months the project had responsibility for only 20% of this (approximately 2,600) and then ended up with 40% of the population (those eligibles whose medicaid numbers ended in 3, 5, 7 & 9) or 5,200 children instead of the 13,000 originally anticipated. Even within this element a further factor comes into play in that the overall welfare rolls declined unexpectedly so that by 31 December 1976 the 5,200 had fallen to approximately 4,000. This number still left an adequate sample to test the case finding variables and would have for case monitoring except that another factor entered the scene.

The second factor was the significantly lower percentage of problems occurring in children in the Dallas area than was expected. Problem expectancy was based more or less upon the overall reported State experience of 28% of children screened with health problems. In original context there would have been 13,000 children, who with a 30% annual turnover in the welfare rolls would have represented 16,900 program eligible children over the year. Secondly, assuming a 35% successful outreach effort there would have been 5,900 children in the program, 28% or 1,652 of whom would have had health problems. At the normal rate of problems per child (1.5), there would have been 2,478 problems to track or roughly 826 per case monitor. The reduction in population, the 20% project eligible population that prevailed for several months before the 40% was settled upon, the reduced rate of problem findings, all contribute to the fact that only 152 problems were identified for case-management follow-up from February - December 1976.[1] The concept of one case monitor per sector was implemented by the project prior to the reduction from 100% of eligible children to 20% then to 40%. When the factor of the reduced population surfaced consideration was given by the project to placing other responsibilities upon the case monitors to reduce the time available for case monitoring to something more closely identified with the requirement. It would appear that this did not occur since the time sheet summaries indicate 85% to 90% case monitor time committed to case monitoring. With the indicated case load, this was a personnel overkill and the excessively high costs per problem completed ($119) reflect this.

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1 Out of 1,525 medical EPSDT screens (10% problem rate).

Notwithstanding the absence of "hard" data a special report of the case monitoring activities was done "on-site" and is attached (Enclosure 2). It provides in-depth discussion of developed procedures and reactions by the various categories of case monitors to the tasks of follow-up of problems and immunizations.

Efforts have now been undertaken to rectify the inadequate workload situation and as of 1 February 1977 a combined case finder/case monitor variable will be introduced in Sectors A & B with two different categories of skills PWW I's and CSA III's using the same techniques (in both finding and monitoring). Sector C will still continue with full time case monitors (Welfare Service Technician) and full time case finders. A special sample study of "on-going" activities (Sector D) will be accomplished when sufficient data has been accumulated from the new 402/402S case monitoring system for comparison with results in Sectors A and B.

It is obvious from the case monitoring methodological description discussed earlier in the Chapter that case monitoring as conceived for testing in the Dallas project is largely an administrative type follow-up. It is not case monitoring in the traditional public health nurse concept in which the district nurse visited the homes of the welfare families to assist in the treatment follow-up of family members who had gone to a physician (or clinic) for an illness or emergency and had been treated and then required a nursing follow-up to assure resolution of the illness or injury. Notwithstanding a nurse was included initially as a monitor because so frequently, in many jurisdictions, there was insistance that a nurse be the monitor because of the visualization of traditional roles. The point here was to demonstrate that skill levels below that of short-supply professional nurses could accomplish the follow-up of problems of a nature to assure that resolution was achieved through the health care system. In essence this has been accomplished. The nurse assigned the case monitoring role in Sector C did an excellent job of follow-up of her cases, but she reported in the seven months she was in the role her nursing skills were grossly underutilized. The Project Director concurred with her transfer and a Welfare Service Technician II was substituted. There is considerable discussion of this point in the special study (Enclosure 2).

5. Rate of Problem and Immunization Completions

Workload experienced and resolution of problems and immunizations are reflected in the following table:

Shows for Screen and Related Problems and Immunizations Requiring Follow-up by Sector[1]
(February - December 1976)

	Sector A					Sector B					Sector C				
	Scrns	Refls	Refs Complt	Imm. Need	Imm. Complt	Scrns	Refls	Refs Complt	Imm. Need	Imm. Complt	Scrns	Refls	Refs Complt	Imm. Need	Imm. Complt
FEB	8	8	8[2]	1	1	20	1	1	3	3	53	7	7	3	3
MAR	18	0	0	1	1	50	0	0	4	4	108	15	15	3	3
APR	62	1	1	7	7	23	0	0	2	2	36	5	5	5	5
MAY	69	4	4	4	4	8	1	1	1	1	92	17	17	5	5
JUN	33	5	5	3	3 (1)[3]	14	0	0	1	1	78	8	8	5	5
JUL	66	15	15	8	8 (2)	38	3	3	4	4	40	8	8	1	1
AUG	42	5	5	6	6	14	2	2	2	2	52	8	8	4	4
SEP	54	8	8	8	8	71	1	1	3	3	44	3	3	2	2
OCT	34	4	3	5	3 (2)	52	2	2	11	1	63	7	2	6	0
NOV	23	1	0	5	1	38	0	0	3	0	67	4	1	5	0
DEC	54	4	2	6	1	43	0	0	8	0	66	5	3	15	0
Total	463	55	51[4]	59	43[5](5)	371	10	10	48	21[5](0)	699	87	77[4]	58	28[5](0)

[1] Sector A - PWW III, Sector B - CSA III, Sector C - Nurse II(February - September);WST II(October - December).
[2] These are all problem completions - treatment completions as well as administrative terminations.
[3] Immunizations brought current for age - all others were administratively terminated.
[4] The difference between the number of "referrals" and "referrals completed" is those cases still pending final resolution at the close of the report period.
[5] The difference between the number of "immunizations needed" and "immunizations completed" is those still pending final resolution at the close of the report period.

Discussion

The above table indicates a 91% completion rate for problems. This is to be expected since sufficient time had not elapsed at the end of this report period for a 100% resolution of those problems identified in October through December. The type of disposition of these cases will be discussed in the next section following.

It is remarkable to find that 77% of children under seven (pre-school) in the Dallas area were current for age in their immunizations at time of screening.

Of the 165 children not current, the follow-up system has now completed action on 92 of these. These follow-up actions reflect that only five were subsequently brought to a "current for age" status and that the others were terminated for a variety of reasons.[1] Discussion with the project Direct Services Supervisor revealed that during the majority of the time covered by this report, no guidelines existed for immunization follow-up. As a result, relatively little effort was expended by the monitors in this area, and the low number of children brought current for age (5) reflects this. Out of 92 cases needing immunization, 61% (56) were essentially not followed up, 39% (36) were followed, of which 14% (5) were successfully brought current for age. As of late September 1976 guidelines have been issued to the case monitors and a concerted effort to bring children current is underway.

The case monitors, attempting to follow up and bring the children with "incomplete immunization" up to a status of "complete for age", report that many of the parents are basically indifferent to the requirements for "complete immunizations". As for EPSDT as a preventive health program, there is a broad base of unawareness of the role of preventive health and immunization, both in the negative and positive senses -- what is prevented and the consequences of non-prevention. The case monitors find that many parents will accept immunizations while present at a health care delivery activity for some other purpose (screening, acute episode, etc.), but will demur from making any "special" effort (trip to a clinic, etc.) solely for that purpose.

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[1] Reasons for inability to complete:

a. Moved 4
b. Not Eligible 15
c. Refused 1
d. Can't Contact 6
e. Repeated Appointment Failure . .5
f. Other 56
g. Immunized 5

As for EPSDT in general to overcome this situation for children over six, in States in which there is no legal requirement for designated immunizations for school admission, or for per-school children, will require long range preventive health education initiatives and short range aggressive outreach efforts such as maximizing immunizations at all normal encounters of children with the health care delivery systems, and assuring adequate reimbursement to providers (both public and private) or taking immunization programs to neighborhoods "at risk" through means of mobile immunization clinics or store front and/or store station clinics (immunization stations in super markets) and associated case finding.

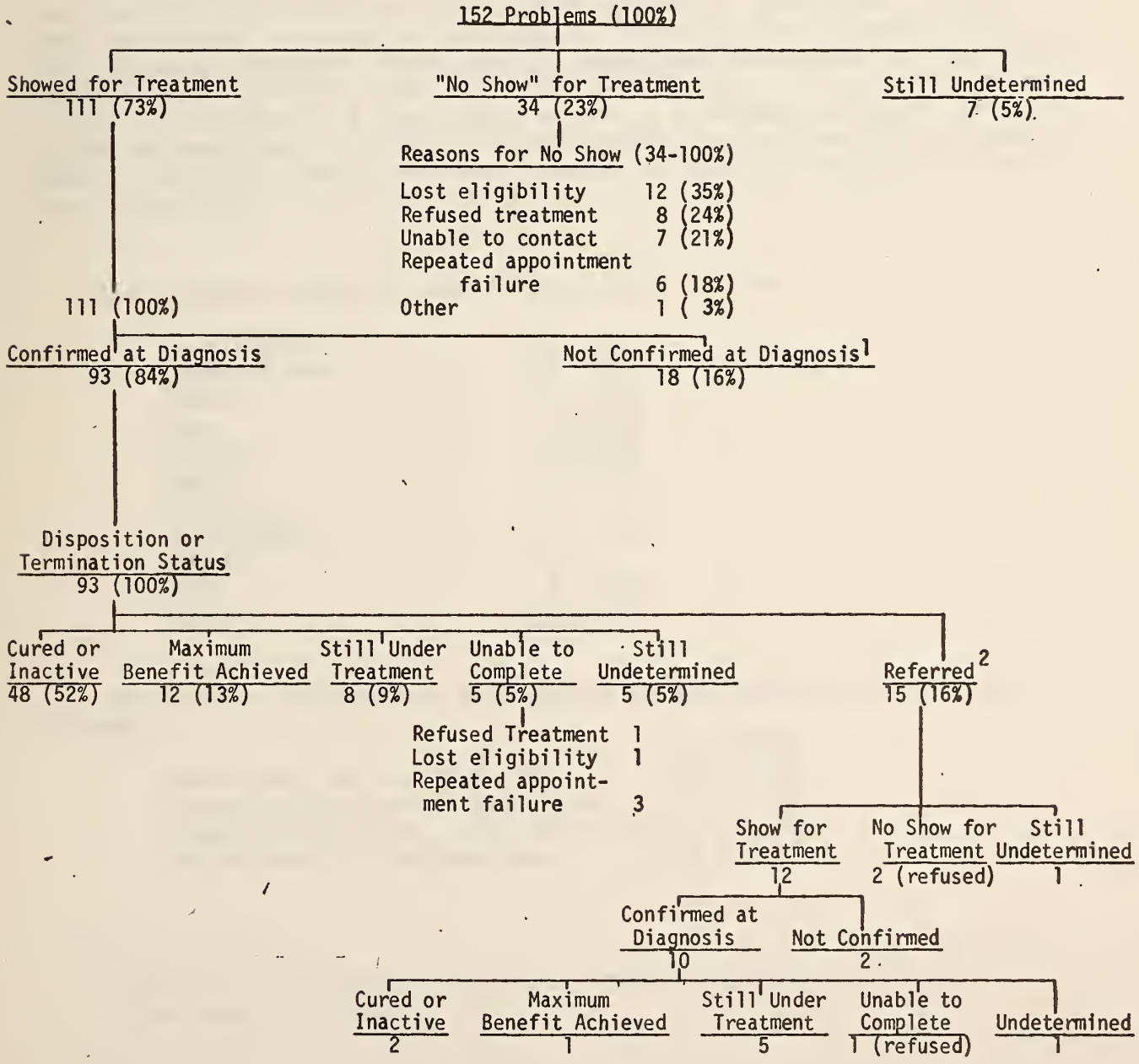
A related and compounding aspect of the overall problem that emerges from other projects and surveys of the EPSDT program in other States is that immunization policy will frequently differ between practitioners, sites and jurisdictions as to the administration of immunizations under circumstances in which the parent has no records and is uncertain as to whether the child had previously received the immunization. Some authorities advocate a policy of "when in doubt, immunize"; others refrain from administering immunizations under such conditions.

There appears to be a need in some national health policy statement concerning administration of immunizations, wherein the status of the series or single immunization is uncertain, if long range and short range aggressive outreach immunization programs are to succeed.

Disposition of Problems

The following schema indicates the disposition of the 152 problems identified in the project from February - December 1976.

Completion Status of 152 Health Problems Identified in Screening of Project Children in the Dallas EPSDT Project (February - December 1976)



[1] Includes "problem not apparent at treatment appointment","treatment not advised or warranted" and "false positives".

[2] Linked referral from initial provider to other provider or specialist.

Discussion:

Of the 93 confirmed problems, 78 (84%) reached some kind of "successful" resolution: condition cured or inactive, maximum benefit achieved, still under treatment after six months, or not confirmed at second referral. Only eight (9%) of these 93 problems were terminated as unable to complete treatment at the end of six months, with the remainder (8%) still of undetermined resolution. This may indicate that if a child can be brought to the first diagnostic visit, he is very likely to successfully complete treatment of his problem. (Many problems are resolved after only one visit to the provider.) The largest "fallout" from the system is at the initial show for treatment (the diagnostic visit). This group may represent those covertly rejecting the program (as discussed in Chapter II) by failing to keep screening appointments. A study will be conducted to determine if a significant number of treatment "no shows" are also screening appointment "no shows" (those showing for a second or third appointment). However, a larger data base (number of cases) is necessary to reach conclusive results.

The problems identified were categorized as follows:

Nutritional	0
Blood Disease	19 (13%)
Mental	5 (3%)
Eyes	9 (6%)
Vision	35 (23%)
Ears	9 (6%)
Hearing	1
Respiratory	9 (6%)
Dental	0[1]
Skin	8 (5%)
Other	57 (38%)
	152

The parents' awareness of the problems at the time of screening was as follows:

	142[2] (100%)
Completely new to the parent	81 (57.0%)
Known to the parent - under care	1 (.5%)
Known to the parent - not under care	50 (35.0%)
No response to the questions	10 (7.5%)

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[1] Dental is a separate program and reported separately in Texas.
[2] Confirmed at diagnosis.

Of the category "known to parent - not under care", 15% were vision problems, 10% were enuresis, 10% were skin problems, 4% were hearing or ear problems, 4% were dysuria, 4% were vaginal discharge and the balance were a multiplicity of conditions such as chest pain, headaches, overweight, underweight, etc.

The average length of time between referral date and treatment initiation was 32 days.

This average length of time is within the range of normal expectancy.

The average length of time between referral date and treatment completion was 58 days.

This factor will be more completely analyzed by special study by problem type in the next report. It leads to the conclusion that most problems found in screening are resolved with one or two treatment visits and only an exceedingly small number run to multiple visits over prolonged periods of time.

Chapter IV

COSTS

In the chapters on case finding and case monitoring, rates were identified which would be used to evaluate the effectiveness of the variables being tested in the respective subsystems. The full impact of these rates, however, also has to be considered in terms of their costs. The complete expression of the rates including costs, is as follows:

Case finding

Effectiveness element	Cost element
(1) Rate of "shows for screen" to eligible population, by technique being tested, by sector	*per average cost per show
(2) Rate of "family contacts" per week, by type aide	*per average cost of contact
(3) Rate of screening appointments made to children in family contacted (sector)	*per average cost of screening appointment
(4) Rate of appointments kept (shows for screen) to children appointed, by technique (sector)	*per average cost of appointment kept

*Case finding subsystem costs divided by the average number of actions in a specific time frame.

Case monitoring

Effectiveness element	Cost element
(1) Rate of problem completions, of problem sheets initiated (by time) by type monitor (sector)	*per average case monitoring cost of problem completions
(2) Rate of case completions (of multiple problem sheet cases initiated, by time) by type monitor (sector)	*per average case monitoring cost of case completions
(3) Rate of screen completions of screening sheets initiated, by time, by type monitor (sector)	*per average case monitoring cost of screen completions

(4) Rate of immunization completions of immunization sheets not completed at screening, by time, by type monitor (sector)	*per average case monitoring cost of immunization completions

*Case monitoring subsystem costs divided by the average number of actions in a specific time frame.

All the guidelines, forms (examples attached), instructions, etc., for collecting and reporting cost data by the project are included in the EPSDT Demonstration Model - Evaluation Handbook published by HSRI in May, 1975. The basic cost data collection Individual Worksheet and the instruction sheet covering its preparation are included in Appendices 2 and 4 to Chapter V, this report, for reference.

The system devised was, to a great extent, a result of the Institute's experience in establishing cost data systems for the "old" demonstration projects (i.e., Cuba, New Mexico; Contra Costa, California; Washington, D.C.; San Antonio, Texas).

The cost elements of analysis, e.g., average cost of shows for screen, average cost of problems completed, etc., are dependent upon

(1) accurate reporting of project employee hours by subsystem or designated major activity;

(2) accurate reporting of total costs per month chargeable to specifically designated accounts.

Direct costs, such as salaries, screens, treatments, etc., are relatively easily identified with subsystems (case finding, screening, diagnosis, treatment and case monitoring) for specific components of time (or sector).

Indirect costs such as rent, utilities, maintenance, depreciation and administrative support (e.g., recruiting, classification, etc.) are generally not as easily identified with a subsystem. To overcome some of these difficulties, the HSRI cost system prescribes the charging of indirect costs to subsystems or major activities, based upon the percent of personnel hours committed to each subsystem. Nevertheless, it was anticipated, particularly in governmental activities in which indirect costs such as utilities and rent are often programmed by an organizational activity other than the EPSDT operation, that the total indirect costs by category chargeable to the EPSDT activity per element of time would be difficult to obtain.

This was the case in the Dallas project and the major factor in diluting the reliability of the cost data for the first three months of the project's activity (February, March, April). The project is a unit of the State Department of Public Welfare and shares a building and associated services with several other functional activities, a situation which, under the prevailing accounting method, apparently does not readily relate costs to activities. The Project person

designated to complete the cost data was unable to acquire the delineated costs (charges) from the appropriate officials in the Dallas area for the time frame of the first report. As an alternate solution, the project used a State provided figure (used in State planning for indirect costs) for computing the indirect project costs. This figure, $892 per person per year,[1] was used in the first report. The cost data developed for this report are reasonably the actual costs for the project component.

A second factor adversely affecting the collection of cost data was the organizational problem between "ongoing" and the project that is discussed in depth in Chapter VI, "The Project in Perspective." Since Phase I (establishing a data base representative of the ongoing activity) was omitted, the cost data from the control sector is vital for comparison purposes. Difficulty in obtaining time sheets from "ongoing" workers without leverage to assure delivery created a void in cost data from ongoing for the period of this evaluation. This matter was not brought under control until the latter part of this report period when the organizational dichotomy between ongoing and the project was resolved. Notwithstanding there are still some extrapolations being utilized to project control costs. It appears that these will be eliminated by the third report.

I. Overall Costs

(a) Direct Services Costs (excludes project overhead/management, etc.)

Period	FTE's[2]	Hours Worked	Direct Costs		Indirect Costs	Total Costs
			Personnel	Travel		
Feb-Mar	8.31	2,730	$14,655	$683	$1,283	$16,621
Apr-May-June	9.50	4,447	24,161	717	2,119	26,997
Jul-Aug-Sept	9.40	4,505	26,665	1118	2,783	30,566
Oct-Nov-Dec	11.50	5,028	34,024	1090	2,526	37,640
						111,824

[1] Includes all indirect operating expenses (rent, utilities, telephone, equipment maintenance, furniture, special equipment, postage, gasoline, oil). It does not include consumable supplies (paper, forms, pencils, etc.). (It is an HSRI estimate that the inclusion of consumable supplies would alter the figure by, at most, 1 - 2%).

[2] Project case monitors, case finders, and inherent supervision and support.

(b) Total Cost ($111,824) by Functional Category[1]

Period	Case Finding	Case Monitoring	Orientation and Training	Administration and Management	Total Costs
Feb-Mar	6,670	6,998	691	2,262	$ 16,621
Apr-Jun	10,164	12,540	1,634	2,659	26,997
Jul-Sep	12,843	11,370	2,010	4,343	30,566
Oct-Dec	15,689	12,456	2,049	7,446	37,640
Total	45,366 (41%)	43,364 (39%)	6,384 (6%)	16,710 (14%)	111,824 (100%)

II. Case Finding Costs

(a) Case Finding Costs ($45,366) per Family Contact by Category of Case Finder (by quarter (Feb-Dec 1976))

Period	No. Families Contacted		Total Cost Attributable to Category of Case Finder		Costs Per Family Contact	
	PWW I's	CSA II's	PWW I's	CSA II's	PWW I's	CSA II's
Feb-Mar		169		6,670		39.47
Apr-Jun		226 (395)		10,164 (16,834)		44.97 (42.62)
Jul-Sep	115[2]	114	4,502[2]	8,341	39.15[2]	73.17
Oct-Dec	137 (252)	138 (252)	8,156	7,533 (15,874)	59.53 (51.23)	54.50 (62.99)

[1]Based upon time sheet data.

[2]These data really reflect only approximately six - seven weeks of costs and activities. (PWW I's hired on or about August 1976).

(b) Case Finding Costs ($45,366) per Child Contact by Category of Case Finder (by quarter (Feb-Dec 76))

Period	No. Children Represented by Family Contact		Total Cost Attributable to Category of Case Finder		Costs per Child Contact	
	PWW I	CSA II	PWW I	CSA II	PWW	CSA II
Feb-Mar		433		6,670		15.40
Apr-Jun		551 (984)		10,164 (16,834)		18.45 (17.74)
Jul-Sep	311	265	4,502	8,341	14.48	31.48
Oct-Dec	389 (700)	355 (620)	8,156 (12,658)	7,533 (15,874)	20.97 (18.08)	21.22 (25.60)

(c) Case Finding Costs ($45,366) per Show for Screen by Category of Case Finder (by quarter (Feb-Dec 76))

Period	No. Shows for Screen		Total Cost Attributable to Category of Case Finder		Cost per Show for Screen	
	PWW I	CSA II	PWW I	CSA II	PWW I	CSA II
Feb-Mar		241		6,670		27.68
Apr-Jun		206 (447)		10,164 (16,834)		49.34 (37.66)
Jul-Sep	176*	109	4,502*	8,341	25.58*	76.52
Oct-Dec	211 (387)	170 (279)	8,156 (12,658)	7,533 (15,874)	38.65 (32.71)	44.31 (56.90)

*Not fully reflective of the whole quarter - close to six rather than 13 weeks

(d) Case Finding Costs[1] per Show for Screen by Two Groups of Case Finders (Same Skill Level) Using Different Techniques

	No. Shows for Screen		Total Cost Attributable to Category of Case Finder by Sector (Technique)		Cost for Show for Screen	
	Sector A and B[2]	Sector D[3]	Sector A and B	Sector D	Sector A and B	Sector D
Oct-Dec	211	135	8156	5451	38.65	40.38

[1]Adjusted to reflect only that part of the "on-going" workers time attributable to case finding.

[2]In-home/face-to-face contact (full time case finder)

[3]Letter/telephone contact (part time case finder - part time case monitor)

(e) Discussion

The indicated overall and functional cost data per se, for project activities is in a high order of accuracy and dependability.

The only variable impacting these overall costs is that which would be derived from sub-allocating 3%[1] of the total costs to case finding and case monitoring as the normally expected amount of time that would be spent in "orientation and training" and "administration and management". The residual 17% (Table 1 b, total of training and administration = 20% - 3% (as normal ongoing costs in this category) = 17%) is orientation, training, administration, and management unique to a research project and not appropriately charged to operations (case finding and monitoring). This circumstance does not affect the comparisons made in the Tables II, a, b and c, though it would increase by 3% the absolute values in each instance. Additionally, it does not impact the comparison in Table II d, since the 3% to administration and training was excluded from the costs of ongoing.

The application of these data to specific task elements is complicated by a multiplicity of factors already discussed in the Case Finding and Case Monitoring chapters and Chapter VI, The Project in Perspective, i.e., decreased population, concomitant overcommitment of staff to workload, particularly in Sector C, delayed interagency agreements between ongoing and project, low problem finding rates, etc. These factors in many aspects were adjusted by September/ October and, as a consequence, the October/December cost figures are considered to be reasonably representative, as applied to specific task elements.

As discussed in the Case Finding chapter, some component of the "Cost per Show for Screen" (Table (c) above) for the CSA II's in October - December must be attributable to the more difficult tasks in case finding an eligible population already heavily contacted almost to the point of saturation.

(f) Case Finding Rates and Costs (Sectors A & B vs C - Same techniques two different categories of workers)

Tables II a, b, and c, preceeding identify costs identified with the performance factors upon which the two categories of workers (PWW I and CSA II) were evaluated in Chapter II. Following is a summary table combining the primary rates of performance analyses and associated costs upon which the conclusions in Chapter II were predicated:

---

[1]The amount of time allocated to training and administration reported by ongoing workers (Sector D) on their time sheets.

Summary
Case Finding Rates and Costs
(PWW I's and CSA II's, Using the same case finding technique--
in-the-home / face-to-face contact)

	PWW I Aug - Dec		CSA II Feb - Jun	
	Rate	Cost	Rate	Cost
Family Contacts per FTE	26.25 (per mo)	$51.23 (per contact)	27.23 (per mo)	$42.62 (per contact)
Child Contacts per FTE	73.0 (per mo)	18.08 (per contact)	70.50 (per mo)	17.74 (per contact)
Child Show for Screen	44% (Ave.5 mo) Aug-Dec	32.71 (per show)	32% (Ave 5 mo) Feb-Jun	37.66 (per show)

(g) Case Finding Rates and Costs (Sectors A & B vs D - Same categories of workers - different technique)

The comparison of costs between the case finders in the project (A & B) and ongoing (D) indicated in Table (d) above should be reasonably accurate for the quarter indicated since both are predicated upon "worker" time sheets. As indicated in the case finding chapter, this reflects a major shift in ongoing worker effort from case finding to case monitoring (from 90% case finding pre-project to approximately 50% one year later (October - December)).

III. Case Monitoring Costs

As already discussed, case monitoring costs during this period have been severely distorted by an unexpected drop in caseload. They should, at this point, in no way be considered representative of case monitoring costs to be expected in an ongoing program.

Case Monitoring Costs ($43,364) per problem completed by Sector (Type Case Monitor) (February - December, 1976)

1 Type Case Monitor (Sector)	2 Total Functional cost per Period Indicated	3 Allocation of Total Functional Cost by Sub-function: Prob.& Immun. Follow-up[1]	4 Allocation of Total Functional Cost by Sub-function: Dental 1st Appt. F.U.[2]	5 Prob.& Immun. Units of Activity: Prob.	6 Immun.	7 Total	8 Cost per Problem/ Immunization Completion
A - PWW III	(Feb-Dec) $15,862	$8,724	$7,138	39	43	82	$106[3]
B - CSA III	(Feb-Dec) 12,749	7,012	5,737	3	20	23	304
C - Nurse II	(Feb-Sep) 10,155	5,585	4,570	49	28	77	73
C - WST II	(Oct-Dec) 4,598	2,529	2,069	19	0	19	133
Total & Average	$43,364	$23,850	$19,514	110[5]	91	201	$119[4]

[1] 55% of case monitoring effort

[2] 45% of case monitoring effort

[3] Column 3 ÷ column 7 = column 8

[4] If normal expected problem identification had occurred (2.8 times greater) this number should be in the order of $42.00 (119 ÷ 2.8 = 42.50). If the eligible population had remained as originally programmed (1.6 times greater), this number should be in the range of $26 - $30 (42.50 ÷ 1.6 = $25.56).

[5] The difference between 152 problems identified in other tables and this is that these are problems upon which all action has been completed.

The "cost per problem completion" reported above is, as elsewhere indicated, totally distorted by the severely reduced caseload/worker ratio.

As reflected in the footnoting, taking cognizance of the originally projected population base and problem referral rates reduces the total average cost per problem/immunization completion to an approximate range of $26 - $30. This is a range of average costs that could have been expected. However, it is wholly an estimate and not of any greater value than the data indicated.

Adjustments made in the project configuration to develop a more reasonable caseload/worker ratio and project a continuance of the current "problem finding" rate by the "ongoing" screening team are to convert the full time case finders/case monitors in the project to combined case finders/case monitors at two different skill levels (employing the in-the-home/face-to-face contact as a technique.)

Notwithstanding, the lower costs for the nurse reflected above results from the higher number of units of activity involved over a shorter period of time. This was due to the fact that there were generally two to three case finders working in Sector C for the whole period in which the nurse did case monitoring; whereas in Sectors A and B, there was little project case finding being done until August 1976 when the PWW I's were specifically hired for this purpose.

Chapter V

THE DATA SYSTEM AND DATA MANAGEMENT

General

Information must be gathered on the clients of EPSDT at various points of encounter in the EPSDT process in order to obtain the data necessary to describe the program. The information is obtained by having service personnel who come in direct contact with the client complete special data forms. Due to the volume of forms involved in a project the size of the one in Dallas, it would take a monumental effort with a high manpower requirement to manually compile the data from these forms in a manner that would be useful in evaluating the project. Thus, for a project of this scope, it becomes expedient to use an automated data processing system for the storage and retrieval of data. This chapter deals with all aspects of gathering data and utilizing an automated information system to perform an analysis.

Data Collection Forms

The basic components of this information system are the various data collection forms. There are four forms used to obtain data about clients in the Dallas project. These are the Family Contact Form, the Project Data EPSDT Screening Sheet, the Immunization Annex, and the EPSDT Medical Referral/Case Monitoring Sheet set. Based upon the variables proposed for testing (grant proposal) and other basic information, a list of data elements essential to the research was drawn up. From these lists and the experience gained from the use of forms in other projects, a set of forms was drafted. These forms were pretested at the project and then revised, using feedback from the pretest. Copies of these forms, as well as the basic screening form (TDHR-DPW Form 400 Sept 75), may be found in Appendix 2.

Forms Distribution

Prior to printing the forms it was necessary to conceptualize how the information requested would be obtained and then disseminated; i.e., who needed copies of forms. In order to visualize the process involved in completing the forms, a set of flow diagrams was developed (See Appendix 3). Using the diagrams as a stepping stone to more completely understand the data collection process, a set of instructions for the use of each form was drawn up. A complete set of instructions can be found in Appendix 4.

From examination of the flow diagrams, it is apparent that they all end at the point where the On-site Data Coordinator transmits the appropriate copies to the HSRI. The remainder of this chapter will concentrate on what takes place once the forms are received at the HSRI.

Systems Equipment (Hardware)

As mentioned in the opening paragraph, an automated data system is used to process the information. The HSRI is set up for remote entry to an IBM 370/158 computer located at San Antonio College (SAC). The computer has two megabytes of main memory running under VM/370. A brief description of the release of VM/370 implemented at SAC is found in Appendix 1. HSRI is linked to SAC via a leased phone line which supports a 3755 RJE (remote job entry) station and four 3277 display terminals (T.V. - like). Figure 1 (page 67) shows the communication links between the equipment that is available to the HSRI.

In terms of input of project data, the system currently uses one of the 3277 display terminals. An operator enters data through this terminal running under the control of CICS programs. CICS is a programming language and system similar to that used by the airlines for on-line entry and retrieval. A terminal operator can enter approximately 500 documents (forms) per day. Keypunching and verification of cards is eliminated. The advantage to this is that when a name or number conflict appears or a code is out of range, the computer will not allow the form to be entered. Editing is performed "on line."

Software Development

By the end of this report period (Dec 30) programs were operational for the Family Contact, Project Screening, Immunization and Referral systems. All systems allow for entry, update, inquiry, and change. The systems are constructed in such a way as to require a minimum of effort on the part of the operator. The CICS programs only allow entries in specific fields on the screen, thus reducing the chance of error and enhancing the speed of entry. Data entered under CICS control is stored as ISAM files on 3330 disks. A detailed description of the software configuration follows Appendix 1 of this section.

Data Access and Analysis

There are two primary means by which the researcher may access the information once it is entered and stored. One is by the inquiry method, which is accomplished by entering a specific client's number, and in the screening system, one additional element of identifying information. The record for that client is then automatically displayed on the screen. This method will retrieve only one case at a time and is generally used to pinpoint errors or to find very specific information. The other method by which the researcher accesses the data is through the pre-programmed statistical package SPSS (Statistical Package for the Social Sciences). Since SPSS works only on sequential files, a routine is executed to produce a sequential file from the on-line ISAM file. Through SPSS the researcher is able to look at either a single variable or multiple variables for the total cases on the file or any defined subset. A wide range of statistical procedures are available ranging from simple frequencies to factor analysis. It is through the use of SPSS that the rates are obtained and compared in order to test the hypotheses on which the demonstration is based.

The SPSS programs are written under the control of the CMS operating system, a versatile system allowing direct entry of program code via a display terminal, or the 3767 typewriter terminal. Once a program is written, it is transferred to the VS 1 operating system for execution. The output is received at the RJE Station printer.

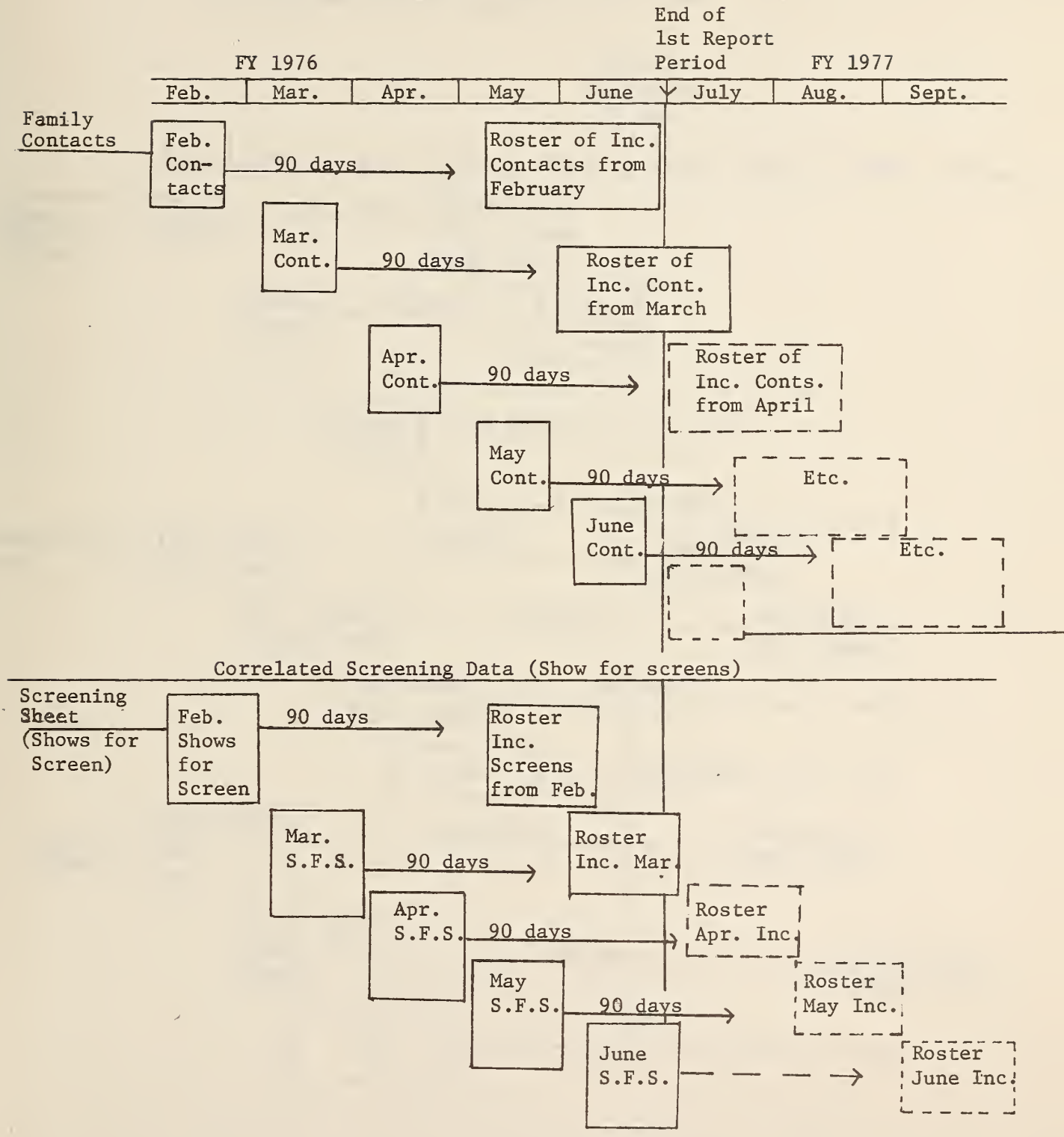
State Provided Lists of Program Eligibles

Also used in the analysis process are tapes of EPSDT eligibles sent each month from the Texas DPW data processing center. These tapes must be physically carried to SAC but the programs run against them are entered from the HSRI. The tapes are necessary in determining the penetration rates in the project. The names of "shows for screens" from the project data EPSDT screening sheet (Form T-406, see Appendix 2, following) are matched against eligibles as reflected on specific monthly tapes to determine the penetration rates at specific points in time.

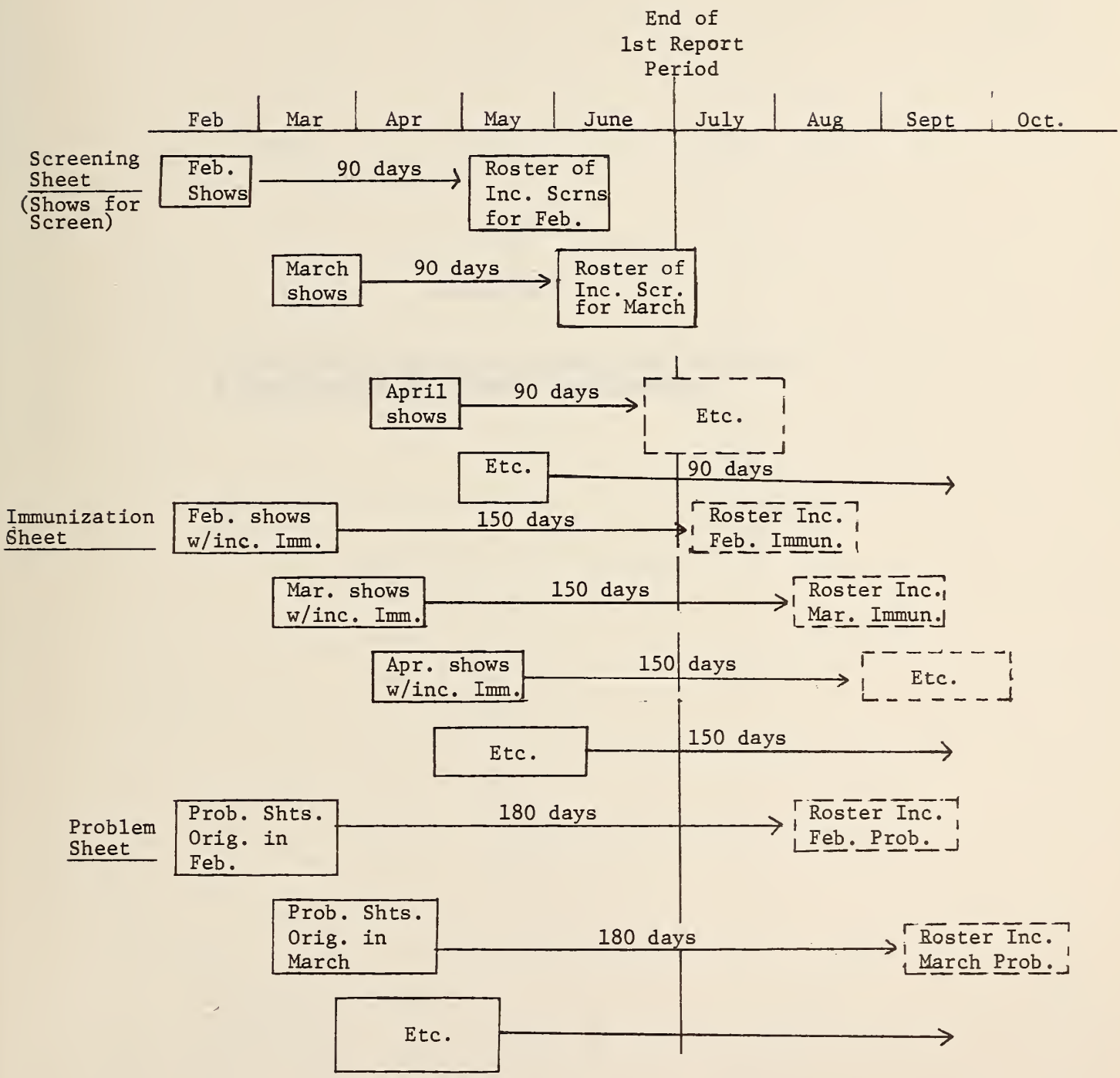
Full Cycle Data System

One other task for which the automated system is used is the production of monthly management rosters. These are lists of project data forms which have not been completed after a prescribed period of time. The time sequence schema of these various management rosters is indicated below. The project personnel are given 21 days to complete actions indicated by the roster and to return them to the Institute. This is a tool used to avoid forms being neglected or lost over the course of the project. It has proven to be a most successful management tool.

THE CASE FINDING FOLLOW-UP DATA SYSTEM



THE CASE MONITORING FOLLOW-UP DATA SYSTEM



Appendix 1

A - HSRI Data Processing Hardware Configuration
B - Description of Software Configuration

Figure 1

HSRI DATA PROCESSING HARDWARE CONFIGURATION

SOFTWARE CONFIGURATION

I. Virtual Machine Facility

VM/370 release 3 is a control program that manages the resources of a single computer such that multiple computing systems appear to exist. VM/370 provides (1) virtual machines and virtual storage, (2) the ability to run multiple operating systems concurrently, (3) a conversational time sharing system - the conversational monitor system (CMS), and (4) a remote job entry manager, the remote spooling communications sub-system (RSCS). CMS provides, at a terminal, a full range of conversational capabilities: file creation and management; compilation, testing and execution of application programs. RSCS provides the remote user with the capability to automatically transfer files between: (A) VM/370 users and remote stations, (B) remote stations and other remote stations, (C) remote stations and a CMS batch virtual machine.

II. Operating Systems

A. OS/VS1 Release 5.0A
B. CMS Release 3 (Conversational Monitor System)
C. RSCS Version 1.0 (Remote Spooling Communications Subsystem)

III. Supporting Software (OS/VS1 Machines)

A. Batch Monitor (Local and Remote Job Entry):
JES/RES (Job Entry System/Remote Entry System)

B. Teleprocessing Monitor (Local and Remote):
CICS VS/Release 1.1.1 - High Level Language Processing
(Cobol and PL/1)

C. Student Oriented Batch (SOB) Compilers:
1. SPASM - Single Pass Assembler
2. WATFIV - Fortran Compiler
3. WATBOL - AND Cobol Compiler
4. PL/C - Student PL/1 Compiler
5. SCRIPT - Text Processor

IV. Supporting Software (CMS)

A. Assembler
B. Basic
C. OS/VS Cobol Version 3.0
D. VS/APL (A Programming Language)
E. WATFIV Interactive Fortran
F. SPASM Single Pass Assembler
G. FORTRAN IBM's Fortran 'G' Compiler
H. PL1 IBM's Optimizing Compiler Version 1 Release 2.3
I. SORTF Fast Sort for CMS
J. CALC Desk Calculator for CMS

V. Other Supporting Software

A. CVIS Computerized Vocational Information System
B. CTSS Classroom Teachers Support System
C. PSSP PL/1 Scientific Subroutine Package
D. FSSP Fortran Scientific Subroutine Package
E. OPTIC5 Test Scoring System, Used with OMR
F. ASMG Assembler 'G'
G. SPSS Statistical Package for the Social Sciences
H. BMD Biomedical Computer Programs
I. CW3 Coursewriter III - CAI Package
J. EASYTRIEVE

Appendix 2

Data Collection Forms

TEXAS DEPARTMENT OF HEALTH RESOURCES
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM
REPORT OF MEDICAL HISTORY AND SCREENING

TDHR-DPW
Form 400
Jan. 1976

RECIPIENT OF SCREENING

1. D.P.W. No.	2. Name (last, first, mi)	3. Social Security No.	4. Birthdate mo - yr	5. Sex	6. Race

7. Phone No.	8. Address (street, city, zip code)	9. County

PARENT, GUARDIAN, RECIPIENT PAYEE

10. Name (last, first, mi)	11. I request my child (I) have a health screening Signature	12. Request Date

STATE EMPLOYEE OR REPRESENTATIVE

13. Signature-state employee or representative	14. Date	15. DPW Region No.	16. Unit No.	17. Mail Code	18. Phone and Ext.

19. Family Physician	20. Remarks

It should be understood that this is an initial medical screening and not a diagnostic procedure.

ITEM	NO	YES	COMMENTS
100. Premature			
101. Birth Defects			
102. Birth Injury			
103. Medical Treatment			
104. Hospitalization			
105. Tremors			
106. Difficulty in Sleeping			
107. Trouble Making Friends			
108. Bed Wetting			
109. Swelling of Nodes			
110. Swelling of Joints			
111. Skin Trouble			
112. Severe Headaches			
113. Hay Fever			
114. Dizzy Spells			
115. Frequent Colds			
116. Frequent Cough			
117. Bloody Sputum			
118. Eye Infections			
119. Vision Problems			
120. Frequent Ear Trouble			
121. Hearing Impairment			
122. Frequent Nose Bleeds			
123. Frequent Sore Throats			
124. Chest Pains			
125. Short of Breath			
126. Abdominal Pain			
127. Diarrhea			
128. Constipation			
129. Worms			
130. Vaginal Discharge			
131. Urethral Discharge			
132. Painful Urination			
133. Venereal Disease			
134. Allergies			
135. Menstrual Abnormality			
FAMILY HISTORY			
136. Diabetes			
137. Cardiovascular Disease			
138. Kidney Disease			
139. Cancer or Leukemia			
140. Mental Retardation			
141. Tuberculosis			

Patient's Name: _____ DPW Recipient No. ☐ ☐☐☐☐☐☐ - ☐☐

72 TDHR-DPW Form 400 Page 2 Jan. 1976

IMMUNIZATION OR BOOSTER STATUS

	INCOMP.	COMP.
142. Diphtheria		
143. Tetanus		
144. Whooping Cough		
145. Measles		
146. Polio		
147. Rubella		

	NEG.	POS.	Not Done
148. TB Mantoux			

MENTAL HEALTH AND PHYSICAL SCREENING

700. Temperature

701. Height: In.

702. Weight: Lb.

703. Blood Pressure: /

	N	ABN	Not Done	COMMENTS
704. Mental Health Screening				
705. Vision Screening				
706. Hearing Screening				
707. Development Progress (DDST)				
708. Musculoskeletal				
709. Extremities				
710. Lymphatics				
711. Skin				
712. Head				
713. Hair				
714. Scalp				
715. Eyes				
716. Ears				
717. Nose				
718. Mouth				
719. Throat				
720. Neck				
721. Lungs				
722. Breast				
723. Heart				
724. Abdomen				
725. Hernia				
726. Genitalia				
727. Reflexes				
728. Endocrinopathies				
729. Teeth				

	NEG.	POS.	NOT TESTED
800. Urine Sugar			
801. Urine Albumin			
802. Urine Bilirubin			
803. Urine Blood			
804. Hemoglobin			
805. Hemoglobinopathies			
806. RPR			
807. Lead			
808. PKU			

900. Refer by Item No. – Date	Comments

Provider No.

Screener's Signature:

Location:

Date of Screening:

Reviewed by: M.D.

Date of Review: (Signature)

TDHR–White; Physician/Other Agency–Green; DPW–Yellow; Parent–Pink; Med. Screening Site–Gold

State of Texas
Department of Public Welfare

Form T-405
January 1976

EPSDT FAMILY CONTACT FORM

Head of Household Medicaid No. ☐ ☐☐☐☐☐☐ ☐☐

Date of Contact ☐☐ ☐☐ ☐☐ (Mo. Day Yr.)

Casefinder ☐☐

Head of Household Name, Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First ☐☐☐☐☐☐☐☐☐☐

Sector ☐☐

Address _____ ZIP _____ Phone _____

Ethnicity

Black	1 ☐
White	2 ☐
Spanish Surname	3 ☐
American Indian	4 ☐
All Other _____	
_____	5 ☐

Outcome of Contact

Willing to Participate	1 ☐
Unable to Locate Family	2 ☐
Refused to Participate	3 ☐
Screened in Another Program	4 ☐
Other _____	5 ☐

ELIGIBLES IN HOUSEHOLD

	No.	Name	Age	Sex		Date for Screen	Appmt. Time	✓ if Trans. Req'd.	Screen Location
1	☐☐				1				
2	☐☐				1				
3	☐☐				1				
4	☐☐				1				
5	☐☐				1				
6	☐☐				1				
7	☐☐				1				
8	☐☐				1				

More than 8 children in family? ☐ Yes – If yes, initiate second sheet and staple together.

Name of Casefinder _____ Head of Household _____

State of Texas
Department of Public Welfare

Form T-406
January 1976

PROJECT DATA
EPSDT SCREENING SHEET

Medicaid No. or Client No. ☐ ☐☐☐☐☐☐ ☐☐

Date ☐☐☐☐☐☐ (Mo. Day Yr.)

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐ (First) ☐ (M.I.)

Sex M ☐ F ☐

Birthdate ☐☐☐☐☐☐ (Mo. Day Yr.)

Ethnicity
- Black 1 ☐
- White 2 ☐
- Spanish Surname 3 ☐
- American Indian 4 ☐
- All Other ____________ 5 ☐

Screening Site
- Oak Cliff 1 ☐
- Swiss Ave. 2 ☐
- Martin L. King 3 ☐
- Lion's Club 4 ☐
- Other ____________ 5 ☐

Case Monitor Code ☐☐☐

Sector ☐☐

Length of time at current address ____________ Yrs. ____________ Mos.

Length of time on Medicaid ____________ Yrs. ____________ Mos.

Transportation to Clinic
- Drove Self 1 ☐
- Free Taxi 2 ☐
- Brought by Welfare Staff 3 ☐
- Rode with Friend/Relation 4 ☐
- Walked 5 ☐
- Rode Bus/Taxi (Pub. Trans.) 6 ☐
- Rode Welfare Vehicle 7 ☐
- Other Specify____________ 8 ☐

Referred by (Check main factor)
- Newspaper ad 1 ☐
- Radio notice 2 ☐
- T.V. notice 3 ☐
- School 4 ☐
- Letter notice 5 ☐
- Walk-in 6 ☐
- Home visit (Casefinder) 7 ☐
- Phone call (Casefinder) 8 ☐
- Neighbor 9 ☐
- Other Specify____________ 10 ☐

Medical Care During Past 12 Months

No Contacts ☐

	Number of: Check-ups	Sick Visits
Private physician	☐	1 ☐
Outpatient Clinic	☐	2 ☐
Hosp. Emergency Room		3 ☐
Hosp. (inpatient) Adm.		4 ☐
Dentist	☐	5 ☐
Optometrist/Ophthal.	☐	6 ☐
School Physical	☐	7 ☐
Other ____________	☐	8 ☐

Screening Sequence
- Original EPSDT ☐
- Periodic Rescreen ☐

Date for Rescreen ☐☐☐☐☐☐ (Mo. Day Yr.)

Visit Number: 1 2 3 4

tate of Texas
epartment of Public Welfare

IMMUNIZATION ANNEX

F 75

Form T-407
January 1976

Medicaid No. or Client No.

Date ____ Mo. ____ Day ____ Yr.

Name ____ Last ____ First ____ M.I. Sex M ☐ F ☐

Age ____ Yrs. ____ Mos.

Case Monitor Code ____

Sector ____

IMMUNIZATIONS	AGE AT SCREENING							CURRENT STATUS				
								Routinely required for child this age?	Has child had this immunization—including this visit?		Subsequent immunizations—current series (within 4 months of this visit) only.	
	2 - 4 Mos.	4 - 6 Mos.	6 - 11 Mos.	12 - 17 Mos.	1 1/2 - 5 Yrs.	6 - 13 Yrs.	14 - 21 Yrs.	✓ If Req'd.		Enter Date Received	Date Required	Date Received
DPT #1		■	■	■	■	■	■	1				
TOPV #1		■	■	■	■	■	■	2				
DPT #2			■	■	■	■	■	3				
TOPV #2			■	■	■	■	■	4				
DPT #3				■	■	■	■	5				
TOPV #3				■	■	■	■	6				
MEASLES					■	■	■	7				
RUBELLA					■	■	■	8				
MUMPS					■	■	■	9				
DPT after age 18 mos. (#3 or 4)						—	—	10				
TOPV after age 18 mos. (#3 or 4)						—	—	11				
DPT after age 4 yrs. (#3, 4, or 5) (Td if given after age 6)							—	12				
TOPV after age 4 yrs. (#3, 4, or 5)							■	13				
Td within last 10 yrs.								14				

KEY

DPT Diptheria and tetanus toxoids combined with pertussis vaccine

TOPV Trivalent oral polio vaccine

Td Combined tetanus and diphtheria toxoid (Adult Type).

☐ DO AT THIS AGE

■ DO AT THIS AGE ONLY IF NOT DONE AT PREVIOUSLY SCHEDULED AGE

*Enter "Date Required" only for immunizations to complete a current ongoing series such as DPT or TPOV. According to the schedules on this page no such date should be later than 4 mos. of the current visit or an entry in the column "has child has his immunization?" Accordingly immunizations will be considered current only if there is an entry under "Enter Date Received" for each immunization (✓) checked as required or there is an entry under "Date Received" matching any entry under "Date Required" under the overall heading "Subsequent immunizations - current series only."

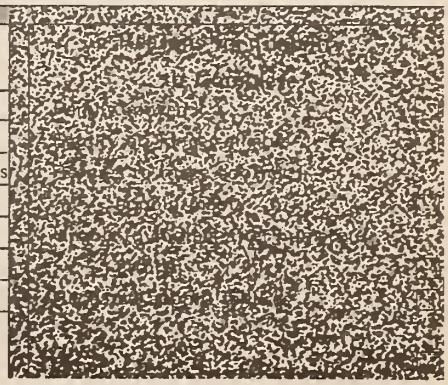
SCHEDULE FOR IMMUNIZATIONS INITIATED IN INFANCY

AGE	VACCINES
2 Mos.	DPT #1, TOPV #1
4 Mos.	DPT #2, TOPV #2
6 Mos.	DPT #3, TOPV #3
2 Mos.	Measles, Rubella, Mumps
18 Mos.	DPT #4, TOPV #4
-6 Yrs.	DPT #5, TOPV #5
4-16 Yrs.	Td (continue every 10 yrs.)

SCHEDULE FOR IMMUNIATIONS INITIATED AFTER AGE ONE

TIME INTERVAL	1—5 YRS.	6 YRS. and OLDER
First visit	DPT #1- TOPV #1	Td (1st)- TOPV (1st)
1 Mo. Later	Measles, Rubella, Mumps	Measles, Rubella,*Mumps
2 Mos. Later	DPT #2- TOPV #2	Td (2nd)- TOPV (2nd)
4 Mos. Later	DPT #3- TOPV #3	—
6-12 Mos. Later	DPT #4, TOPV #4	Td (3rd)- TOPV (3rd)
At age 14-16 Yrs.	Td (every 10 yrs.)	Td (every 10 yrs.)

*Rubella Vaccine should not be given to a post-menarchal girl without physician consultation.



TDHR-DPW
Form 402
May 1976

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO.

1. PATIENT'S DPW NO.
2. CASE NAME (PAYEE)
3. REFERRAL NO.
4. PATIENT'S NAME (LAST, FIRST, MIDDLE)
5. BIRTH DATE
6. ADDRESS (STREET, CITY, STATE, ZIP)
PHONE NO.
7. DPW WORKER/AGENCY REPRESENTATIVE
DPW WORKER BJN/ AGENCY NAME & ADDRESS
WORKER PHONE NO.

CLIENT INFO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP):
PHYSICIAN PHONE NO.
9. APPOINTMENT TIME
DAY
DATE
10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.
2. SCREEN DATE

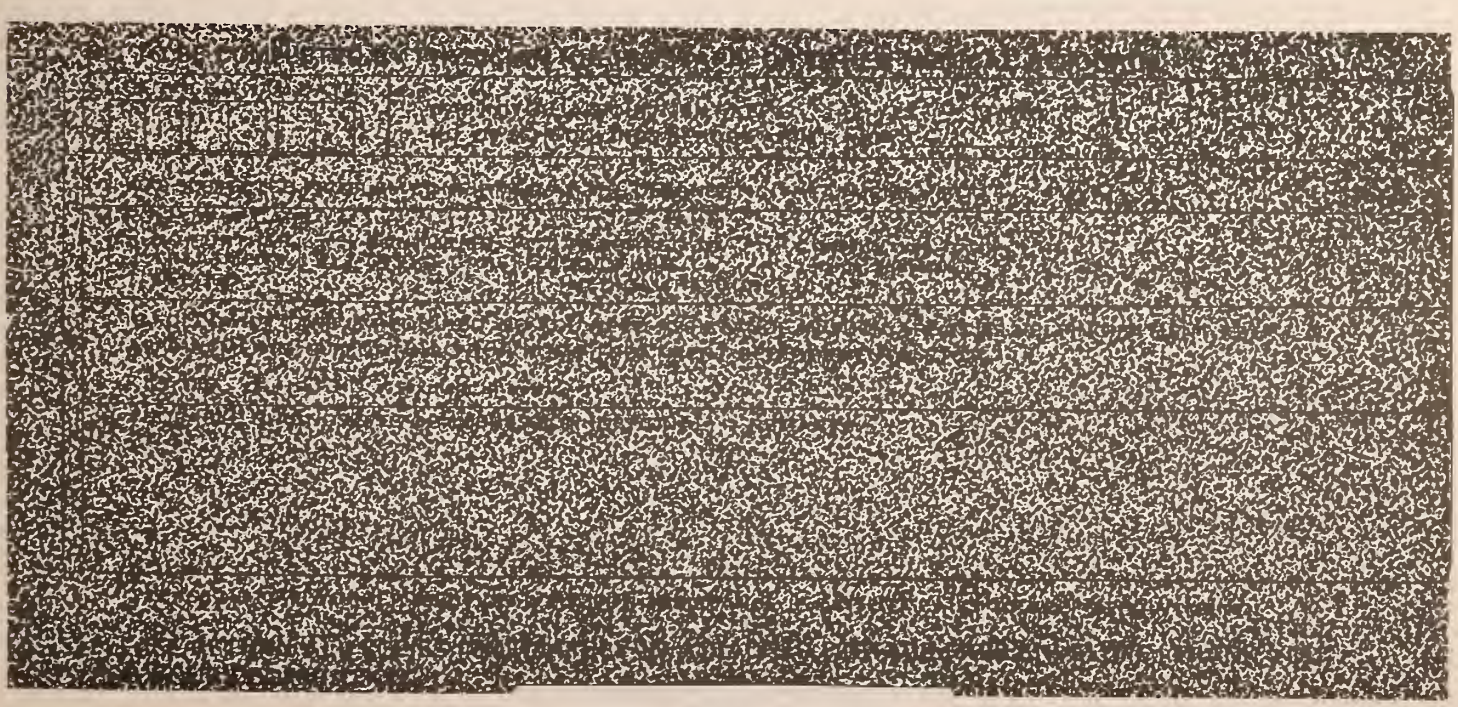
DEAR DOCTOR
THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON
AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.
3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN
SIGNATURE DATE



EPSDT Regional Coordinator

TDHR-DPW
Form 402
SEPT. 1976

1. REFERRAL NO.
M · 017960

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

77

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO.

2. PATIENT'S DPW NO.

3. RECIPIENT'S (PATIENT'S) NAME (LAST, FIRST, MIDDLE INITIAL)

4. BIRTHDATE

5. CASE NAME (PAYEE) (LAST, FIRST, MIDDLE INITIAL)

7. DPW WORKER/AGENCY REPRESENTATIVE

6. MAILING ADDRESS

PHONE NO.

1st LINE

2nd LINE

CITY

STATE ZIP CODE

DPW WORKER BJN & MAIL CODE

WORKER PHONE NO.

AGENCY NAME & ADDRESS (if not DPW)

CLIENT INFO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP):

PHYSICIAN PHONE NO.

9. APPOINTMENT TIME

DAY

DATE

10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

1. TDHR PROVIDER NO.

DER... RM ... AN...
TDHR CLINIC REPORT

DEAR DOCTOR:
THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPARTMENT OF HEALTH RESOURCES ON 2. SCREEN DATE
AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR REFERRAL:

Form 400 Codes

4. REFERRAL DATE

5. IS NATURE OF REFERRAL URGENT? ☐ YES ☐ NO

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OF GUARDIAN

SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PR... R... TO DPW

1. SERVICE/EXAM DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*

NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT?

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE

☐ NO FURTHER TREATMENT NEEDED ☐ CONTINUED OFFICE CARE ☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?

☐ YES ☐ NO (explain, if yes)

6. PROBABLE DISGNOSIS/ES OR IMPRESSION (OPTIONAL) – REMARKS:

*PLEASE NOTIFY WORKER (SECTION 1, No. 7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE.
THANK YOU FOR YOUR COOPERATION.

1. REFERRAL NO. * M

EPSDT MEDICAL REFERRAL SUPPLEMENT 78

Form 402-S
SEPT. 1976

V. A. FOR COMPLETION BY FOLLOW-UP WORKER

2. PATIENT'S DPW NUMBER

3. RECIPIENT'S (PATIENT'S) NAME (LAST, FIRST, MIDDLE INITIAL)

B.

1. EXAMINATION DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ Yes ☐ No
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT?

3. WAS SUSPECTED (REFERRED) PROBLEM CONFIRMED AT DIAGNOSTIC/TREATMENT VISIT? ☐ Yes ☐ No

4. FOLLOW-UP CARE:
☐ NO FURTHER TREATMENT NEEDED | ☐ CONTINUED OFFICE CARE | ☐ REFERRED ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. DOES PHYSICIAN REQUIRE ASSISTANCE FROM WORKER IN HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING HOME TREATMENT PLANS, ETC.? ☐ Yes ☐ No

6. DIAGNOSIS:

7. SOURCE OF INFORMATION: ☐ CLIENT ☐ PHYSICIAN ☐ OTHER

C.

1. REASON FOR NON-COMPLETION OF REFERRAL-TREATMENT PROCESS:
☐ CLIENT REFUSAL
☐ SERVICE UNAVAILABLE
☐ OTHER
} explain ⇨
☐ CLIENT NO LONGER ELIGIBLE ☐ CLIENT NOT LOCATABLE

D.

1. DPW WORKER/AGENCY REPRESENTATIVE NAME

WORKER BJN & MAILCODE

AGENCY NAME AND ADDRESS (if not DPW)

SIGNATURE

DATE

*MUST CORRESPOND TO 402 REFERRAL NO. IN CASE RECORD, SECTION 1, ITEM 1.

7. **Problem Status (180 days after referral date or upon problem completion)**
a. Treatment completed, condition presumed cured or inactive after 1st visit ..... 1☐
b. Treatment plan completed — now cured or inactive (follow-up contact) ..... 2☐
c. Treatment terminated — maximum benefit achieved (not necessarily inactive or cured) ..... 3☐
d. Still under treatment (original practitioner/clinic) ..... 4☐
e. Still under treatment (referred practitioner/clinic) ..... 5☐

8. **Method of follow-up**
Mail ..... 1☐
Phone ..... 2☐
Personal contact ..... 3☐
Other
Specify _____ 4☐

9. **Reasons for inability to complete problem**
Family moved ..... 1☐
Family no longer eligible ..... 2☐
Refuses to make another appmt. ..... 3☐
Unable to contact after numerous efforts ..... 4☐
Repeated appmt. failures ..... 5☐
Other
Specify _____ 6☐

10. **Date form completed**

/ /
Mo. Day Yr.

HSRI

11. **DPW Worker Signature**

State of Texas
Department of Public Welfare

Form T-408
April 1976

[79

EPSDT CASE MONITORING SHEET

1. Patient's DPW No. ☐ ☐☐☐☐☐☐ ☐☐

2. Referral No. ☐☐☐☐☐☐

3. Case Monitor Code ☐☐☐

4. Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐ (First) ☐ (M.I.)

5. Appointment Record

DATE	APPM'T. TIME	APPM'T. KEPT	COMMENTS

6. Narrative Summary of follow-up

_____

_____

_____

_____

_____

7. Problem Status (180 days after referral date or upon problem completion)
   a. Treatment completed, condition presumed cured or inactive after 1st visit ..... 1☐
   b. Treatment plan completed — now cured or inactive (follow-up contact) ..... 2☐
   c. Treatment terminated — maximum benefit achieved (not necessarily inactive or cured) ..... 3☐
   d. Still under treatment (original practitioner/clinic) ..... 4☐
   e. Still under treatment (referred practitioner/clinic) ..... 5☐

8. Method of follow-up
   Mail ..... 1☐
   Phone ..... 2☐
   Personal contact ..... 3☐
   Other
   Specify _____ 4☐

9. Reasons for inability to complete problem
   Family moved ..... 1☐
   Family no longer eligible ..... 2☐
   Refuses to make another appmt. ..... 3☐
   Unable to contact after numerous efforts ..... 4☐
   Repeated appmt. failures ..... 5☐
   Other
   Specify _____ 6☐

10. Date form completed

_____ / _____ / _____
Mo. Day Yr.

HSRI

11. DPW Worker Signature _____

INDIVIDUAL WORK SHEET

Name of Employee: _____ Week of _____ (Monday - Sunday)

Job Title: _____ Job Title No. Code _____

Activity of Assignment _____

Major Activities	Total Hrs. Available This Week	Hours Worked Per Major Activity — Days of the Week							Total Hrs. Worked
		1	2	3	4	5	6	7	
Case-Finding									
Original Screens									
Rescreens									
Screening									
Diagnosis & Treatment									
Case-Monitoring									
Problem Completions									
Screen Completions									
Health Education									
Other Exper. Activ. Specify 1._____									
2._____									
3._____									
Orientation/Staff Trng./Staff Conf.									
Managerial/Adminis.									
TOTAL	*								

* The total of this column will normally be 40 hours unless the individual is a part-time employee. Report below if the available hours include non-productive time, such as sick leave, vacation or a holiday. For example, if one day of leave was taken, indicate below "Includes 8 hours leave."

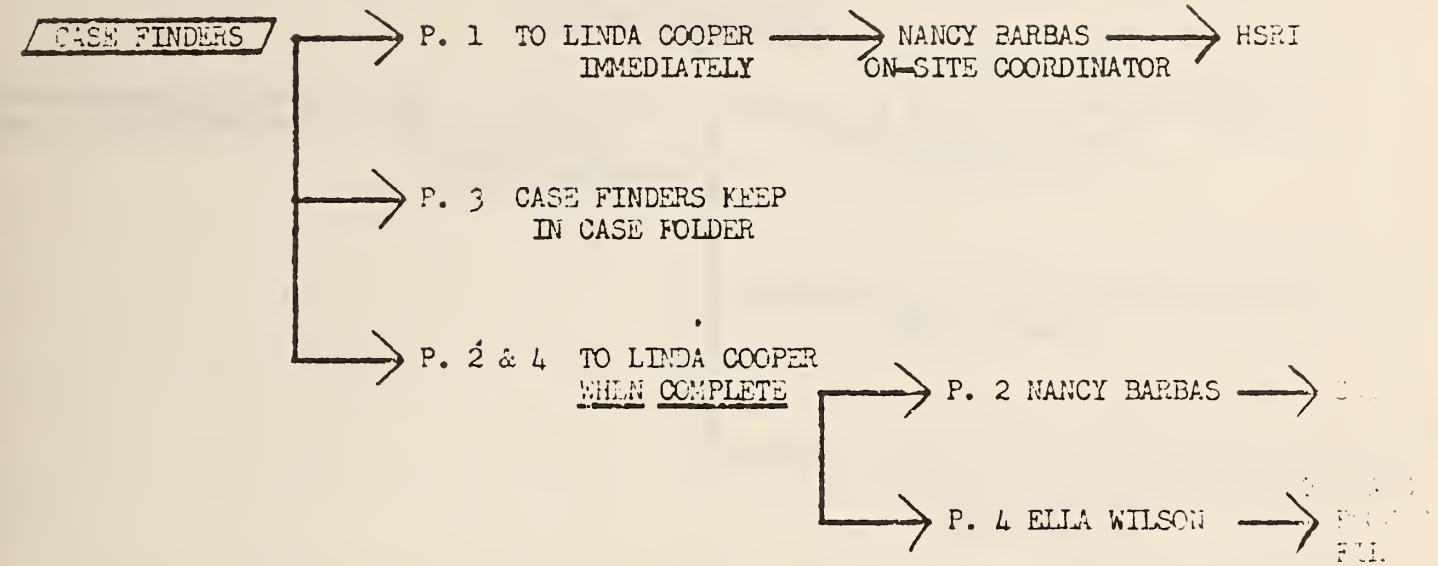
_____

Appendix 3

Form Flow Sheets

Forms Flow

Family Contact Sheet

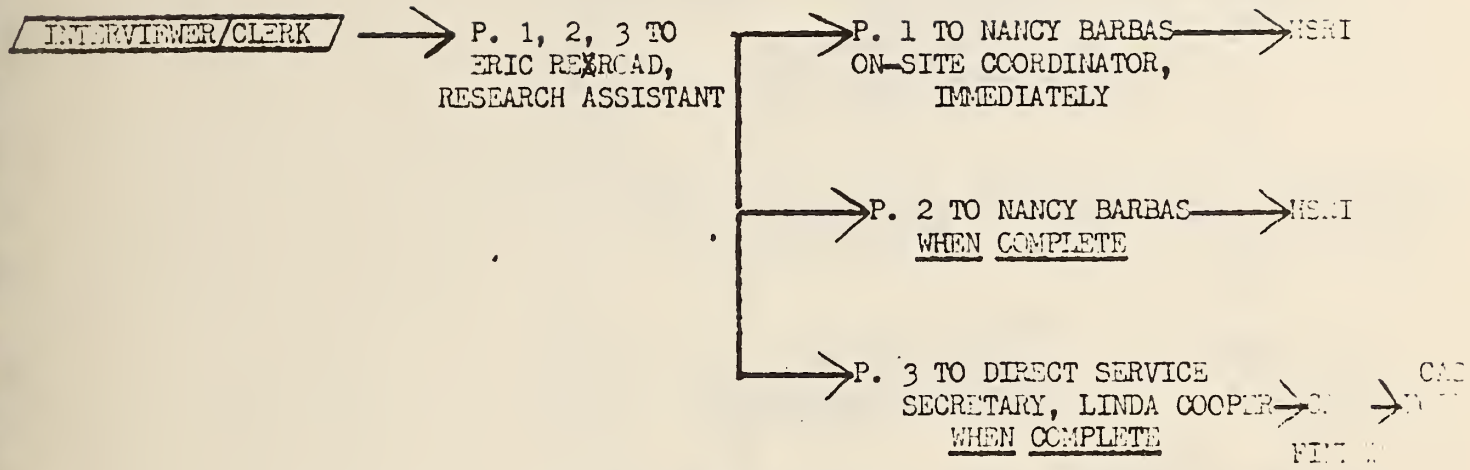


a. The Family Contact Form is orignated by the case finders for each case.
b. After the first meeting with a client when the form is orginated, page 1 is turned in to the Direct Services Secretary, Linda Cooper. * Page 1 is to be turned in within 48 hours of the client contact. Pages 2, 3, and 4 are kept by the case finders in the case folder until complete.
c. The Direct Services Secretary will check page 1 against the case finders appointment list in order to insure that a form has been turned in for each scheduled client contact. On the same day in which page 1 has been received by the Secretary, the Secretary will deliver it to the On-site Coordinator. The On-site Coordinator will send page 1 to the Health Services Research Institute.
d. Pages 2, 3 and 4 are completed after the case finder has confirmed that a screening appointment has been kept or after it is confirmed the family will not keep the appointment (see instructions for filling out family contact form). After completion of pages 2, 3 and 4, page 2 and 4 will be turned in to the Direct Services Secretary.*
e. The Direct Services Secretary will deliver page 2 to the On-site Coordinator who will send page 2 to the Health Services Research Institute. The Direct Services Secretary will deliver page 4 to the Statistical Clerk, Ella Wilson, who will file page 4 in the research project file.

(Special Instructions to Student Interns: Turn in pages as indicated in these instructions to LeVivian Graham, Assistant Project Director, rather than to the Direct Services Secretary

Forms Flow

Project Data Sheet



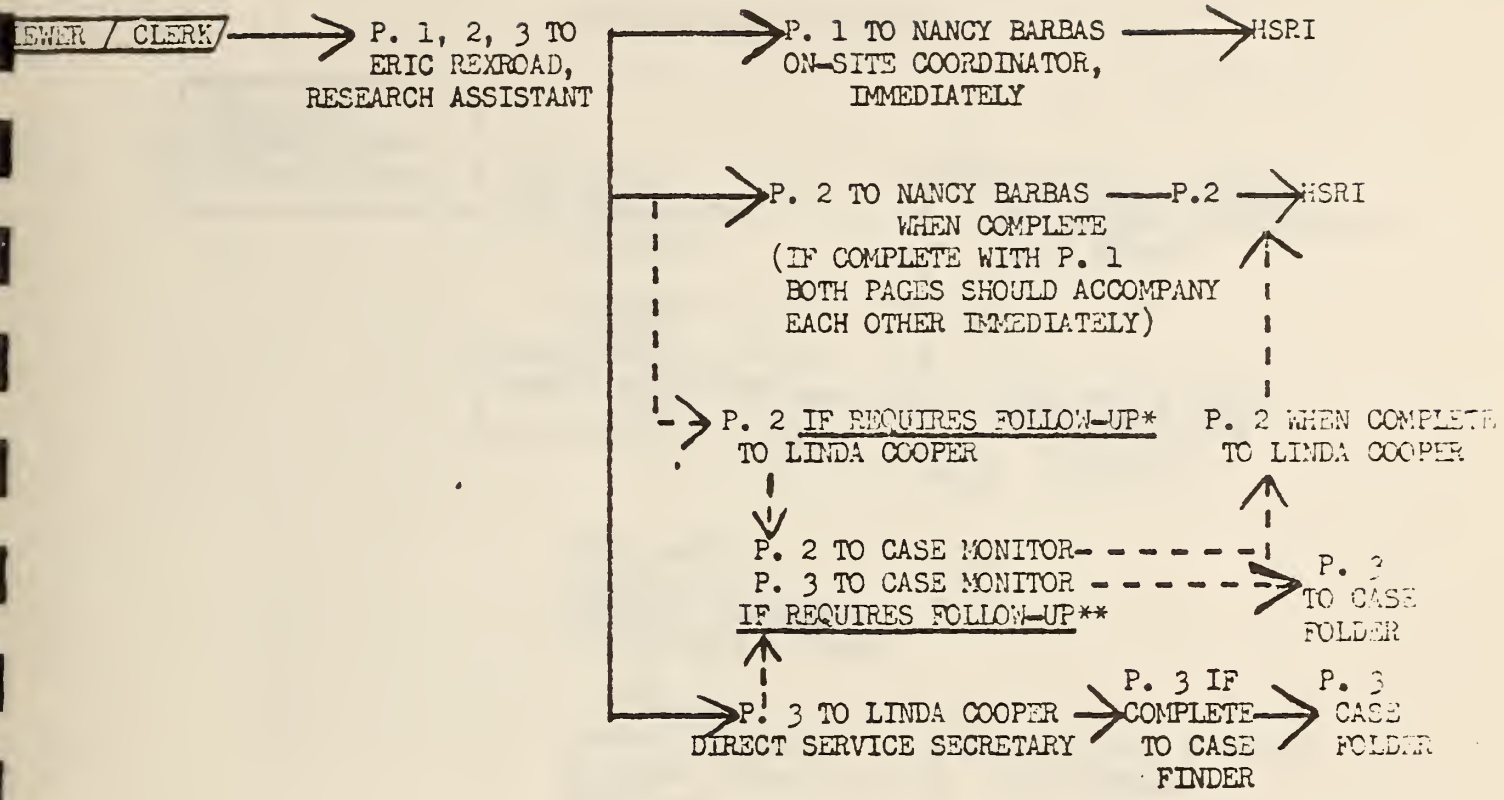
A. The Project Data Sheet is originated at the screening site by the interviewer/clerk for each child/client who is screened and lives within the demonstration area. In order to insure that a Data Sheet is completed for each patient who shows for an appointment, the interviewer/clerk will check off form completions on a clinic appointment schedule.

B. Pages 1, 2 and 3 are to be turned in to the Research Assistant, Eric Resraod, at the end of each clinic day or by the following day at the latest.

C. The Research Assistant will deliver page 1 to the On-Site Coordinator within 24 hours of receiving it, who will in turn send it to the Health Services Research Institute. The Research Assistant and / or statistical clerk will fill in the incompleted portion of the Data Sheet(page 2, 3) when the test results are received by the Health Screening Team. Upon completion , page 2 will be given to the On-Site Coordinator who will send it to the Health Services Institute.

D. Page 3 will be given by the Research Assistant to the Direct Services Secretary who will deliver it to the assigned case finder for filing in the case folder.

Immunization Annex



The Immunization Annex is originated at the screening site by the interviewer/clerk for ch child/client who is screened and lives within the demonstration area.(Originate h Project Data Sheet).

Pages 1, 2, and 3 are to be turned in to the Research Assistant, Eric Rexroad, at the end of each clinic day or by the following day at the latest. (Should accompany Project Data eet).

The Research Assistant will deliver page 1 to the On-site Coordinator within 24 hours of receiving it, who will in turn send it to the Health Services Research Institute.

If no follow-up is necessary and the Immunization Annex is complete, page 2 will be delivered to the On-site Coordinator with page 1, who will send it to HSRI.

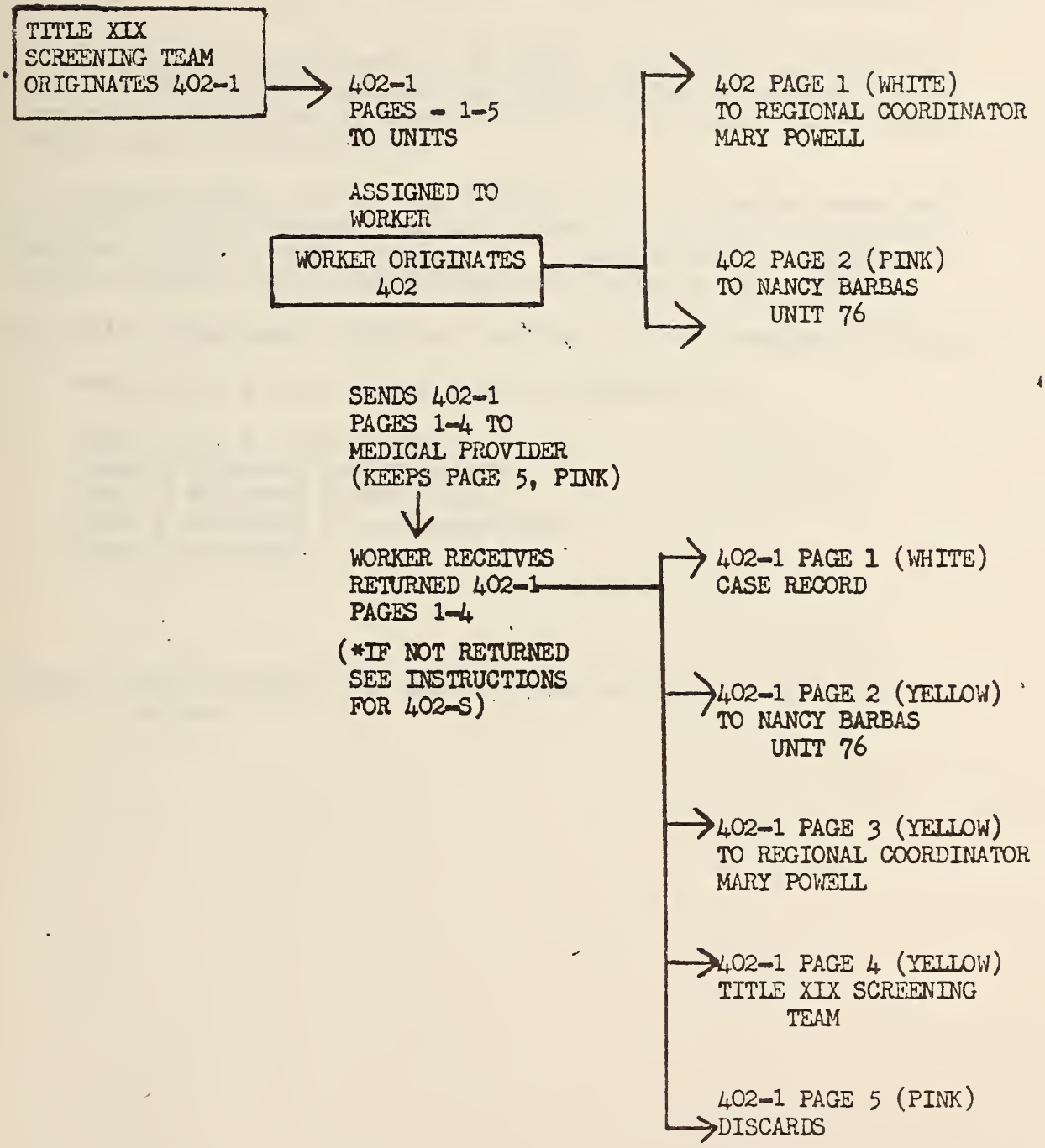
If no follow-up is necessary, the Research Assistant will deliver page 3 to the Direct Services Secretary within 24 hours of receiving it. The Secretary will deliver it to the appropriate case finder who will file it in the case folder.

If follow-up is necessary, page 2 will be delivered to the Direct Services Secretary for assignment to the appropriate case monitor. Upon completion of the Immunization follow-up the case monitor will return page 2 to the Direct Services Secretary who will deliver it to the On-site Coordinator. Page 2 will then be sent by the Coordinator to the Health Services Research Institute.

If follow-up is necessary page 3 will accompany page 2 to the Direct Services Secretary. The Secretary will deliver page 2 and page 3 to the appropriate case monitor who will complete the follow-up and then file page 3 in the case folder.

EPSDT Medical Referrel - Forms 402, 402-1

Distribution Instructions



402, 402-1

1. Form 402-1 is originated by the screening team and all pages sent to the units.

2. The assigned worker receives all pages of the 402-1 and originates F402. It is very important that the 402 be filled out accurately and completely. The 402 is distributed as soon as complete, page 1 to Mary Powell, page 2 to Nancy Barbas.

3. Upon appointing a client for follow-up care, the worker sends pages 1 thru 4 to medical provider (via the client or the mail). Accompanying the 402-1 to the provider should be a.) a postage-paid, pre addressed return envelope. b.) a pre-printed cover letter to the provider.

The worker keeps page 5 (pink) of the 402-1 for case management purposes.

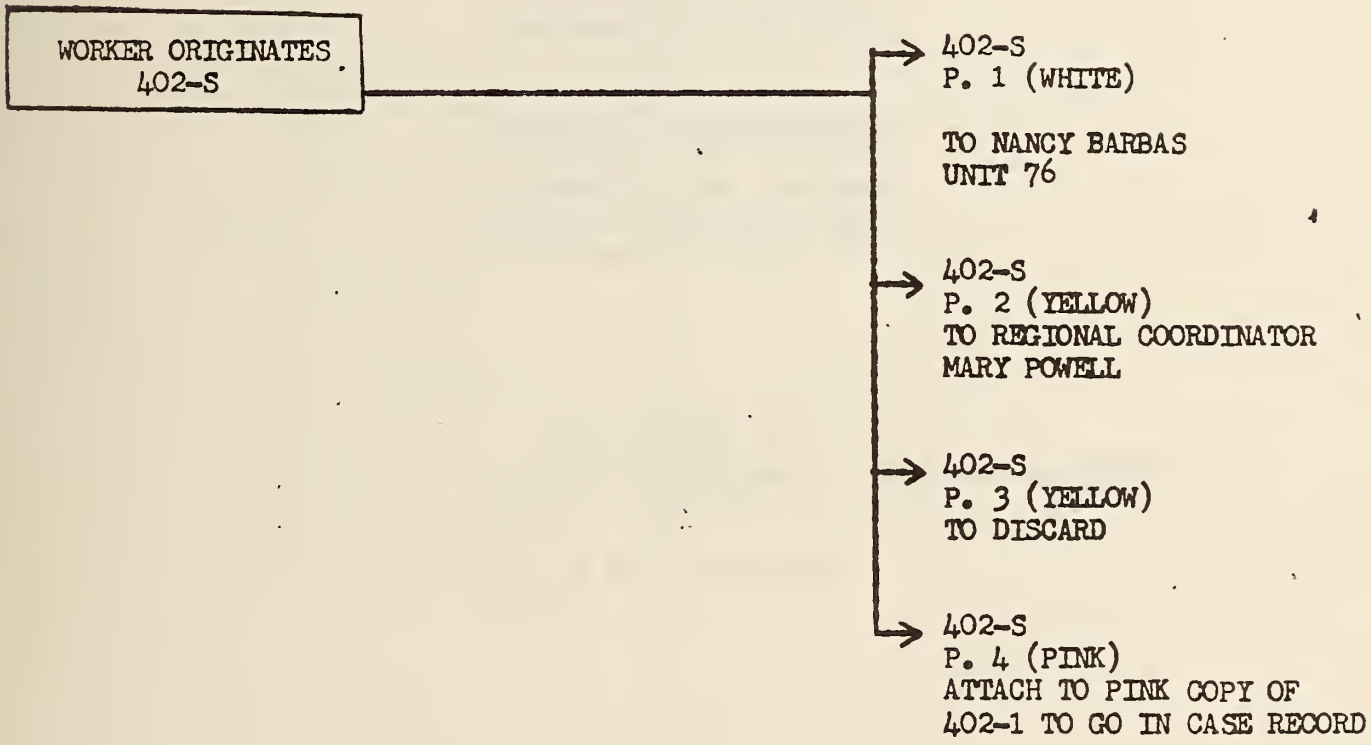
4. When pages 1-4 are returned they are distributed*:

- page 1 stays in case record
- page 2 delivered to Nancy Barbas
- page 3 delivered to Mary Powell
- page 4 delivered to screening team
- page 5 discarded

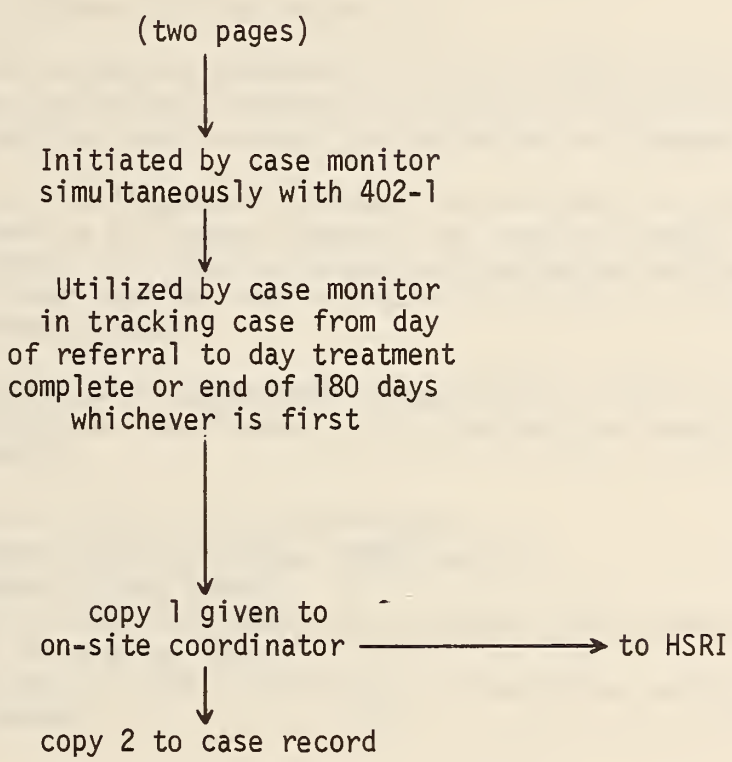
*Note: See instructions for 402-S if 402-1 not returned by Medical Provider.

EPSDT Medical Referrel - Form 402-S

Distribution Instructions



CASE MONITORING SHEET FLOW



402-S

1. Form 402-S is originated by the worker if:

   a. Initiation of diagnosis/treatment has been received and the medical provider has not returned pages 1-4 of the 402-1 to the worker within three weeks of the scheduled appointment.

   b. Initiation of the diagnosis/treatment has not been received and the client is no longer eligible, has refused further services, is not locatable, or other circumstances that indicate a further need for worker follow to intitate the diagnosis/treatment process.

   NOTE: If the client has rescheduled an appointment, F402-S is not originated until three weeks of the rescheduled appointment if necessary.

2. Upon completing the 402-S it is distributed:
   - page 1 delivered to Nancy Barbas, EPSDT Unit 76
   - page 2 delivered to Mary Powell
   - page 3 discarded (Dr. Nancy White has requested that copies of the F402-S not be sent to her).
   - page 4 is attached to page 5, pink copy, of the 402-1 and filed in the case record.

Appendix 4

Instructions for Use of Forms

EPSDT Family Contact Form

A Family Contact Form will be initiated by the case-finding aides for each personal contact (a face to face meeting with a program-eligible head of household is a contact).

1. Head of Household Medicaid No.: Enter in the spaces provided, starting from the left, e.g.,

   Head of Household Medicaid No.

3	4	9	7	6	5	2	0	1

2. Date of Contact: The date of contact to be entered is the date of first "eye to eye" contact with the head of household for the purpose of "selling" the EPSDT program and appointing the children for screening. Fill out the boxes numerically; for example July 4, 1976 would appear as:

0	7	0	4	7	6
Mo.		Day		Year	

3. Name: Enter the last name of the head of household in the spaces provided, then the first name. It is imperative that names be spelled correctly and Medicaid numbers be entered correctly. The names in this section should be the name of the person listed on the eligibility rolls.
4. Address, Zip Code and Phone: Print the address on the line, including apartment numbers if applicable. If there is no phone, write the phone number that the head of household generally receives calls on.
5. Sector: Enter the code for "original" (1) or "periodic" (2) in the first box and the code for sector in the second box.
6. Casefinder Code: Enter your two digit code number in the boxes.
7. Ethnicity: Check the appropriate box to indicate the ethnicity of the head of household.

8. Outcome of Contact: One, and only one, of the boxes should be checked according to the outcome of the interview. If the head of household has indicated a willingness to participate in the program, efforts should be made at that point to make a specific appointment for screening for all, several, or one of the children. If the head of household consents to participate in the program, check "Willing to participate" in this section. If this box is checked, yet no dates for screen and appointment times are entered in the section under "Eligibles in household", it is assumed that the head of household did not feel free to commit to an appointment at that time.

   The system provides that at least two additional efforts should be subsequently made by telephone, personal contact, etc., to schedule the children for a screening appointment. If success in appointing is not achieved by the third contact, the case-finding aide may assume that the family declines participation and the box "Refuses to make another appointment" under the section "Reasons for no show at screen" should be checked. The family will then not again be contacted (if they remain program eligible) until the next normal periodic rescreen sequence for their ages by case-finding personnel. If the family has moved or become ineligible, check "Other" and specify the reason, then check the box that applies in the section "Reasons for no show at screen" of the second page. Staple pages 1 and 2, then forward to OSDC.

9. Reasons for No Show at Screen: This section pertains to cases in which (1) an initial face to face contact has been made, but not all of the children listed have shown for screening, (2) the family has moved away, or (3) lost eligibility. The first case applies after three attempts

at scheduling screening appointments have been made, or after 90 days from date of contact. One, and only one, of the boxes should be checked. If three appointments have been scheduled for a child or children and each has not been kept, assume that the family is not interested in participating and check the box next to "Repeated appointment failures".

10. Eligibles in Household: Enter the two-digit numbers, the names (last name first), ages and sex for all program eligible children in the household. CORRECT SPELLING OF NAMES AND AGE (in years). THIS IS VERY IMPORTANT--PLEASE PRINT.

If the head of household consents to an appointment at the time of initial interview (contact) enter the date, time and location of the appointment, check whether transportation is needed and can be provided.

EXPERIENCE IN OTHER EPSDT DEMONSTRATIONS AND ON-GOING PROGRAMS INDICATES THAT SUCCESS IN HAVING EPSDT SCREENING APPOINTMENTS KEPT DEPENDS SIGNIFICANTLY ON A MINIMAL LAPSE OF TIME BETWEEN THE DATE OF CONTACT AND THE SCREENING APPOINTMENT. THE HIGHEST RATES OF SUCCESS IN SCREENING APPOINTMENTS KEPT WERE WHERE THIS PERIOD WAS LESS THAN FIVE DAYS.

If there are more than eight children in the family, check ☐ Yes at the bottom of the form, and use another sheet to continue the list of eligible children. The Medicaid number, name, date, sector, and casefinder code should be filled out on this second sheet. Staple the two sheets together.

The column "✓ if Appmt. Kept" is used to indicate that the screening appointment has been kept. This will be determined from the appointment roster that is returned to the case finder by the clinic the day after the date of appointment.

Space is provided to allow for three appointments for each child, in the event that appointments made are not kept. If the third appointment is not kept, assume the family is not interested in participating and check the box next to "Repeated Appmt. Failures" in the section "Reasons for No Show at Screen".

11. Name of Case finder: Write your name on the line.

12. Head of Household's Signature: The head of household should sign here after being presented with the opportunity to participate in the program. A signature must be obtained whether the head of household is willing to participate or not. If the head of household refuses to participate, show him/her that you have checked the box next to "Refused to Participate" and ask that he/she sign to verify that he/she has heard the advantages of the program and refuses to participate. Obtaining a signature from a willing head of household is equally important because it further strengthens the commitment to participate and to keep appointments that have been made.

Instructions For Filling Out Project Data Sheet

Items 1 through 9 are to be filled out at the screening site. Most of the information is obtained from the Texas DPW Screening Sheet (F400). These items should be completed before the interview.

1. Medicaid number: Copy from item #1 on F400, writing one digit per box.
2. Date: Write the screening date in the boxes, using two digits each for the month, day, and year.
3. Name: Copy the name of the person being screened from item #2 on F400, entering the last and first names and middle initial in the appropriate boxes with one letter per box.
4. Sex: Check appropriate box for sex as indicated in item #7 on F400.
5. Birthdate: Copy from item #6 on F400, one digit per box.
6. Ethnicity: Look at child's surname to determine if "Spanish Surname" is appropriate. If not, check appropriate box as indicated in item #8 on F400.
7. Screening site code: Check appropriate box. If site is other than one of the four major clinic sites, check "Other" and fill in the specific location.
8. Case monitor code: This three-digit code is broken into two parts. The first digit is an indicator of the skill level of the case monitor. The second two digits are a personal code, specifying a unique employee. Fill-in the appropriate case-monitor code according to the sector in which the client resides.

Sector	CM Code
01	111
02	221
03	331
04	000

9. Sector: The two-digit code is assigned according to the zip code and first

letter of the last name of the caretaker. The codes are as follows:

Sector	Zip Codes	First Letter of Last Name
01	75208 75203 75224 75216	A-J
02	75208 75203 75224 75216	K-Z
03	75215	A-Z
04	75223 75210	A-Z

Items 10 through 17 are questions asked of the caretaker in an interview at the screening site. Introduce yourself and explain that we are conducting a project in order to obtain information which we hope will enable us to improve the health services. Request the interviewee's help in obtaining this information, stating that you would like to ask them a few questions. Ask to see any medical and immunization records they have with them, including any received that day. Refer to these records as an aid to questions concerning medical care, health experience, and immunizations during the interview, but do not depend solely on them for a complete answer.

10. Length of time at current address: Ask: "How many years or months have you lived at your current address?" Record in the blank provided.

11. Length of time on Medicaid: Ask: "How many years or months have you currently been receiving Medicaid without a break?" If the caretaker has been on and off Medicaid, record the current consecutive length of time on Medicaid.

12. Transportation to clinic: Ask: "How did you get to the clinic today?"

"Rode bus/taxi" should be checked if the clients paid for bus, subway, or taxi fare. "Rode Welfare Vehicle" applies if the clients were transported to and from the clinic by a clinic owned vehicle. "Brought by welfare staff" should be checked if the client's caseworker or case-finder brought them. "Free taxi" will apply only to those clients in sector 01 who take advantage of the taxi transportation offered them.

13. Referred by: Ask: "What most influenced you to bring your child in for screening today?" Check appropriate box. "Home visit (casefinder)" and "Phone call (casefinder)" can apply if a caseworker or case finding aide contacted the client.

14. Medical care during past 12 months: This item identifies the place or type of medical care that the client may have had during the previous 12 months for an acute illness (sick visits) or as a preventive health measure (check-up). It is an indicator of the child's general health and the preventive health orientation of the parents. Ask: "Try to recall whether your child (you) has received any medical attention in the last year. I specifically would like to know whether he/she/you has visited:

a doctor's private office?

an outpatient clinic?

a hospital emergency room?

has been admitted into a hospital?

a dentist?

an eye doctor?

had a school physical?

any other medical provider?

(An affirmative response to any of the above categories should each be followed by:)

"How many times did you visit this health care provider? How many of these visits were made because he/she/you were feeling ill and how many visits were made as regular check-ups?" Check the box next to "No Contacts" if the child has had no medical care in the past year. Otherwise, enter the appropriate number of check-ups or sick visits in the boxes alongside each type of health care. Enter "X" in the boxes if some visits were made, but the exact number is unknown.

No Contacts ☐

	Number of:	
	Check-ups	Sick Visits
Private Physician	☐	☐
Outpatient Clinic	☐	☐
Hospital Emergency Room		☐
Hospital (Inpatient) Admissions		☐
Dentist	☐	☐
Optometrist/Ophthalmologist	☐	☐
School Physical	☐	☐
Other (Specify)_____	☐	☐

15. Screening sequence: Ask: "Is this the first time your child (you) has been to a welfare-sponsored screening program?" If the child has been screened before in any EPSDT program, including another state's, check "Periodic Rescreen". Otherwise, check "Original EPSDT".

16. Date for rescreen: In accordance with the State plan for periodic rescreens, indicate in the boxes the date on which the child will be eligible for his/her periodic rescreen.

17. Visit number: Some screening completions require more than one visit. It is necessary to ascertain the impact of multi-visits on screening and case completions. Ask: "Is this the first visit your child (you) have made to the clinic for this screening or has it been necessary for you to return to complete the screen?" In this instance, circle the number that the current visit constitutes in the ongoing screening sequence. In the initial visit, the screener would have indicated "(1)". On a subsequent second visit, using the same screening sheet, the entry would appear as "(1)(2) 3 4 ", and if, for some unusual reason, a new screening sheet was initiated for this second visit, the entry would appear as " 1 (2) 3 4 ".

Thank the interviewee for his/her time and cooperation.

Items 18 through 23 (on second sheet) are completed when the results from the lab tests are available.

18. Child's healthiness rating: Write in the same number that is circled on the scale stamped on the F400.

19. Tests and measurements: Indicate which of these tests are required at this screen by placing a check in the required column. When the results of the tests are obtained, if the result is normal place a check in the normal column; if the test result is abnormal and the State does not require a retest for abnormal conditions for that test, place a check in the abnormal column. If a retest is required because of an abnormal condition found, place a check in the retest column and leave the two columns on results blank. In this case when the results of the retest are obtained, place a check in either normal or abnormal, whichever is appropriate. When this section is completed, for each check in the required column there should be

a check in either the normal or abnormal column for that test.

20. Total problem sheets initiated: Write in the box the number of problem sheets that were initiated as a result of the screening. This information is obtained by counting the number of clinic copies of problem sheets in a child's record.

21. Staff code of primary screener: The primary screener normally is the person who completes the final review of the screening sheet, determines if any of the problems require treatment, and signs the F400 at the bottom. This three-digit staff code is similar to the case monitor code in that the first digit is an indicator of a screener's qualifications and the other two digits are the screener's personal code. The following are the screening staff codes:

Nancy White	501
Faye Smith	101
Susan Vaughn	102
Karen Alleman	103
Margaret Bushong	104
JoAnn Cook	201
Vora Bell	202
Betty Haywood	203
Carolyn Smith	204
Robbie Saunders	801
Jo Smith	802

22. Screening complete?: It is important to identify the completion of the screening sequence. The screening is complete when the physical examination and the results of all required tests have been returned, when the child's healthiness rating has been entered, and when the staff codes for the persons completing the screening sheet have been entered. Check "Yes" when complete.

23. Reasons for inability to complete screen: This section is to be completed by the case monitor. If the screen has not been completed after the client has failed to keep three consecutive appointments, or at the end of 90 days from the date of show for screen, the case monitor should check the appropriate box.

Immunization Annex

1. Medicaid Number: Enter in the spaces provided the Medicaid number of the person being screened, e.g., | 2 | 3 | 5 | 6 | 7 | 0 | 8 | 0 | 2 |

2. Date: Enter numerically, e.g., Date | 0 | 9 | 0 | 8 | 7 | 6 | (mo. day yr.)

3. Name: Print the last and first names of the person screened in the boxes provided, starting from the left in each case. If the name should contain more letters than boxes on the form, print the remainder out to the side.

4. Sex: Check the appropriate box.

5. Age: Age is included here to provide a ready reference to determine the immunization requirements for this age child generally as a base point to subsequently determine immunizations required for a particular child. Enter numerically, e.g.,

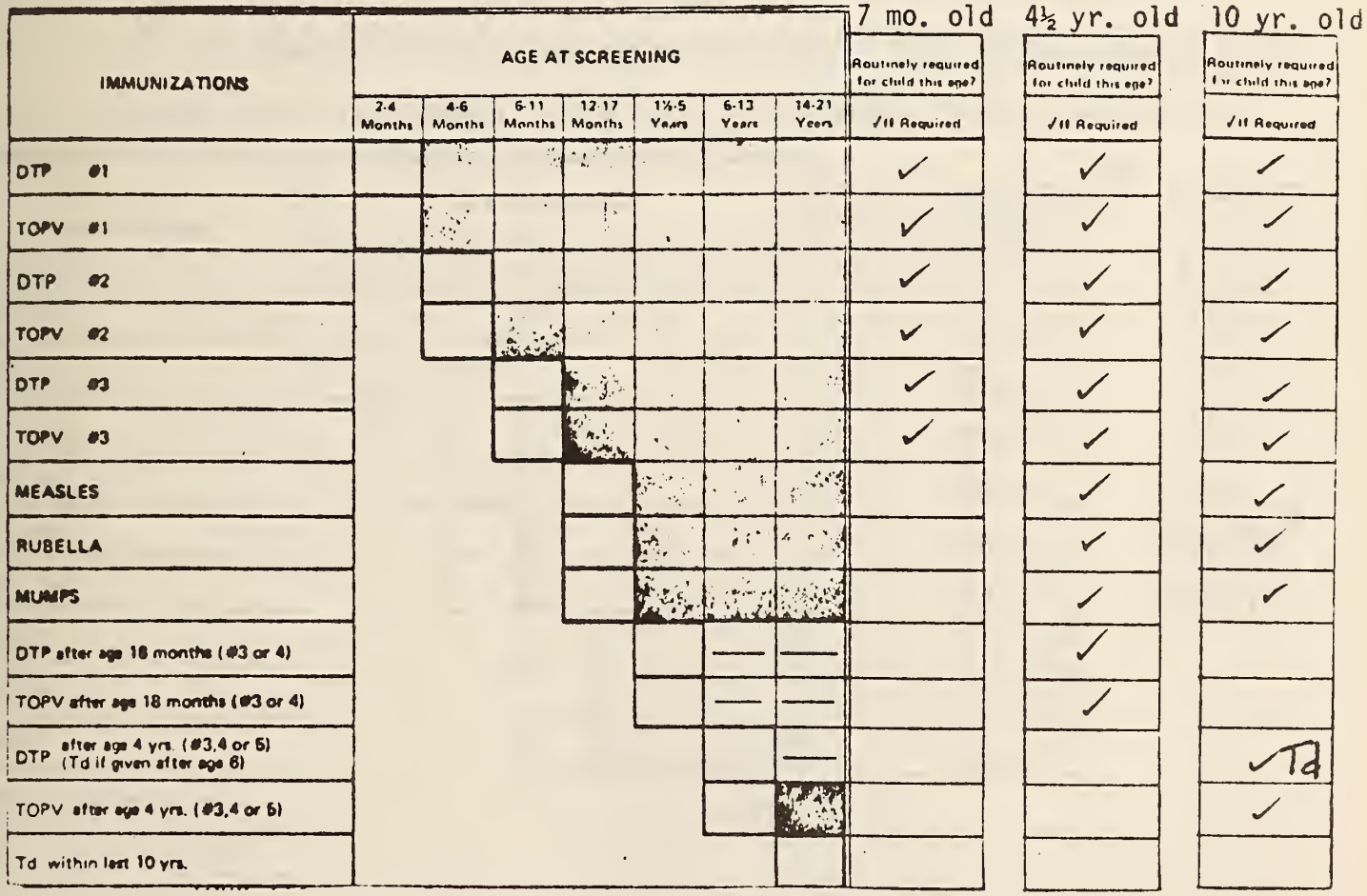
   Age | 0 | 3 | 0 | 6 | (yr. mo.) (3½ years old)

   Age | 0 | 0 | 1 | 0 | (10 months old)

6. Case Monitor Code: Fill in the boxes with the appropriate three digit code. This item is included to assign follow-up responsibility for immunizations. The first digit is an indicator of the skill level of the case monitor. The codes are as follows: 1 - social worker (sector 01)
   2 - assistant (sector 02)
   3 - public health nurse (sector 03)
   The next two digits are unique to the employee and will be assigned upon employment.

7. Sector: The two digit code is assigned as specified in the instructions for the Project Data Sheet, and can be transcribed from that form.

6. Current Status - Routinely Required for Child this Age - Using the age and sex of the child being screened as the sole factors, simply use the appropriate age column on the form under the heading "Age at Screening" as the basis to check each box indicating requirements for specific immunizations, e.g., a child is male and



7. Current Status - Has Child Had this Immunization - Including Current Visit? Enter Date Received - Question the mother concerning the status of each immunization indicated as required by the previous step (paragraph 6). Immunization records kept by parents or recorded in a medical chart

can be accepted as valid. Verbal reports by parents are less valid, but can often be accepted as evidence of immunization. If the child is in school, it can be assumed that the child is up to date on immunizations since state law requires proof of immunization completeness to enter school. If exact dates of immunization are unobtainable, but the caretaker is certain that they were given, simply place a check instead of a date in the appropriate block under this column. If records are available, enter the dates of previous immunizations and then record the date of those shots given at this visit, if any. For example, for a child born November 1970, 3½ years old:

IMMUNIZATIONS	AGE AT SCREENING							Routinely required for child this age?	Has child had this immunization - including this visit?	OR Has child had this immunization - including this visit?
	2-4 Months	4-6 Months	6-11 Months	12-17 Months	1¼-5 Years	6-13 Years	14-21 Years	√If Required	Enter Date Received	Enter Date Received
DTP #1								✓	Jan. 71	1971
TOPV #1								✓	Jan. 71	1971
DTP #2								✓	Mar. 71	1971
TOPV #2								✓	Mar. 71	1971
DTP #3								✓	May 71	Aug. 7, 74*
TOPV #3								✓	May 71	Aug. 7, 74*
MEASLES								✓	Aug. 7, 74*	
RUBELLA								✓	Aug. 7, 74*	
MUMPS								✓	Aug. 7, 74*	
DTP after age 18 months (#3 or 4)						—	—	✓		
TOPV after age 18 months (#3 or 4)						—	—	✓		
DTP after age 4 yrs. (#3,4 or 5) (Td if given after age 6)							—			
TOPV after age 4 yrs. (#3,4 or 5)										
Td within last 10 yrs.										

*Indicating those given at the current visit

8. Current Status - Subsequent Immunizations, Current Series Only (Within Four Months of Current Visit) - Date Required - This column, as well as the next one, is to be completed by the case monitor assigned to this case. Comparing the two previous steps (columns), which will have indicated the immunizations required and

those received in the past and the current visit, the action in this instance is to schedule additionally required immunizations by entering the date the next immunizations are due in the four following months; e.g.,

(Date of Birth, November 1970 - 3 1/2 years old)

IMMUNIZATIONS	AGE AT SCREENING							CURRENT STATUS			
								Routinely required for child this age?	Has child had this immunization - including this visit?	Subsequent immunizations current series (within 4 months of this visit only)	
	2-4 Months	4-6 Months	6-11 Months	12-17 Months	1¼-5 Years	6-13 Years	14-21 Years	√ If Required	Enter Date Received	Date Required	Date Received
DTP #1								✓	Jan. 71		
TOPV #1								✓	Jan. 71		
DTP #2								✓	Mar. 71		
TOPV #2								✓	Mar. 71		
DTP #3								✓	May 71		
TOPV #3								✓	May 71		
MEASLES								✓	Aug. 7, 74*		
RUBELLA								✓	Aug. 7, 74*		
MUMPS								✓	Aug. 7, 74*		
DTP after age 18 months (#3 or 4)						—	—	✓		Oct 1, 74	
TOPV after age 18 months (#3 or 4)						—	—	✓		Oct 1, 74	
DTP after age 4 yrs. (#3,4 or 5) (Td if given after age 6)							—				
TOPV after age 4 yrs. (#3,4 or 5)											
Td within last 10 yrs.											

*Indicating those given at the current visit.

9. Current Status - Subsequent Immunizations - Current Series Only (Within Four Months of Current Visit): Date Received

Enter the date subsequently scheduled immunizations are received, e.g.,

(Date of Birth, November 1970 - 3 1/2 years old)

IMMUNIZATIONS	AGE AT SCREENING							CURRENT STATUS			
	2-4 Months	4-6 Months	6-11 Months	12-17 Months	1½-5 Years	6-13 Years	14-21 Years	Routinely required for child this age? ✓if Required	Has child had this immunization - including this visit? Enter Date Received	Subsequent immunizations current as of (within 6 months of this visit only) Date Required	Date Received
DTP #1								✓	Jan. 71		
TOPV #1								✓	Jan. 71		
DTP #2								✓	Mar. 71		
TOPV #2								✓	Mar. 71		
DTP #3								✓	May 71		
TOPV #3								✓	May 71		
MEASLES								✓	Aug. 7, 74		
RUBELLA								✓	Aug. 7, 74		
MUMPS								✓	Aug. 7, 74		
DTP after age 18 months (#3 or 4)								✓		Oct 1, 74	Oct 10, 74
TOPV after age 18 months (#3 or 4)								✓		Oct 1, 74	Oct 10, 74
DTP after age 4 yrs (#3,4 or 5) (Td if given after age 6)											
TOPV after age 4 yrs. (#3,4 or 5)											
Td within last 10 yrs											

When this step is completed and the subsequent immunizations received match those required, the child is now completely immunized for its age--the status is current. At the next rescreen in the following year for the child used in the above example, he will require two additional shots (DTP after age 4 and TOPV after age 4) to be considered completely immunized for his age.

EPSDT MEDICAL REFERRAL

Section 1 - to be completed by DPW case monitors.

1. Patient's DPW case number - this is not the payee case number, but the person's number who has been screened and referred.
2. Case Name (payee) - enter the name of the person receiving grant (head of household).
3. Referral number - pre-stamped six-digit number.
4. Patient's Last, Middle, and First Name - enter the last name of the individual referred, then the first and middle names.
5. Birth Date - enter by digits the date of birth. Example: 07/08/75.
6. Address - Street/Route - City/Town - Zip - Phone number - enter client's address and phone number. Write sector code at end of address space.
7. DPW Worker/Agency Representative Name - print name of DPW case monitor, DPW BJN and case monitor code, and phone number. For example:
   Prunella Smith | 011-00-R-02-600-077-2/222 | 372-4671
8. Referred to - enter physician or appropriate medical resource's name, address, and zip code where the client is scheduled for an appointment.
9. Appointment time/day/date - enter appointment time, etc.
10. Rescheduled appointment(s) - for worker use in case record, enter new rescheduling of appointments. (See Case Monitoring Sheet for additional space.)

Section II - to be completed by screening provider.

1. TDHR provider number - enter medical screening provider number.
2. Date of screening - enter by digits (07/08/75) the date on which the client received medical screening.

3. Reason for referral - Record 400 abnormality number and explanation for medical provider. Demonstration project staff should write in major condition category code number in the space between screen date and referral date.
4. Referral date - enter by digits (07/08/75) the exact date the specified abnormality was identified and referred for diagnosis and/or treatment by the screening provider. NOTE: Except in the case of an immediate referral, the screen date and referral date will not be the same.
5. Problem History - Check one. Is the problem referred completely new to the caretaker or was it previously known and either under care or not under care.
6. Authorization for Release of Medical Information to DPW-TDHR - Appropriate person (parent or guardian) must sign and date this release. NOTE: Authorized DPW social services/personnel or the person to whom authority has been delegated should sign in the case of a foster child. The DPW worker or contracting agency representative should assist the TDHR screening provider in securing this signature.

Section III - to be completed by physician or his staff or other medical resource. NOTE: Care should be taken to include franked envelopes with the proper return address for the DPW or contracting agency worker.

1. Service or examination date - enter the date of the initial exam. NOTE: This item is very important. If the medical provider does not wish to provide the other information, he/she should enter this date and return all copies.
2. Was initial appointment kept? - Check yes or no if the client did or did

not keep the first appointment set. NOTE: This question is asterisked and refers the medical provider to the EPSDT follow-up worker for assistance if the client does not keep the first appointment.

Number of schedulings before the appointment was kept? - Enter 1 if the first appointment was kept, etc. The data generated from this item will be helpful in evaluating client response to the EPSDT program and, if the treatment is received more than 60 days after screening, will be taken into consideration on penalty regulation compliance.

3. Was the suspected problem confirmed at the diagnostic/treatment visit? - Check one. This data item will be utilized as a check on false positive screening findings.
4. Follow-up care - Check one. Was no further treatment, continued office treatment, or referral to another medical provider needed? Types of medical resources referrals include hospitalization referral, specialist referral, etc.
5. If follow-up care is required, do you need assistance in such areas as... - Check yes or no. This indicates the medical provider needs additional follow-up by the DPW worker to assist the client in following a treatment plan.
6. Probable diagnosis... - This item is optional but would provide needed information on the results of screening and treatment. If more space is required, an additional sheet of paper should be attached.

EPSDT MEDICAL REFERRAL SUPPLEMENT

1. Patient's DPW number - enter the DPW number of the person referred from medical screening, not the payee number.
2. Patient's name - print the last, first, and middle names of the individual referred.
3. Referral number - enter by digits the exact number on the Form 402 in the case record. This item must correspond. NOTE: Complete either items 4 through 10 or item 11, based on information gathered from client and/or physician.
4. Examination date - enter the date of the initial exam. NOTE: This item is very important. If the medical provider does not wish to provide the other information, the worker should enter this date and distribute all copies appropriately.
5. Was initial appointment kept? Number of schedulings before the appointment kept? - Check appropriate box. Enter 1 if the first appointment was kept, etc. The data generated from these items will be used in evaluating client response to the EPSDT program and, if the treatment is received more than 60 days after screening, will be taken into consideration on penalty regulation compliance.
6. Was the suspected (referred) problem confirmed at diagnostic/treatment visit? Check appropriate box. This data item will be used as a check on false positive screening findings.
7. Follow-up care - Check one.
8. Does medical provider require assistance from worker, etc. - Check yes or no.

EPSDT CASE MONITORING SHEET

1. Patient's DPW number - enter number in spaces provided.
2. Referral number - enter the referral number that is pre-stamped on the corresponding 402. It is very important that the referral numbers are correct.
3. Case monitor code - enter in boxes.
4. Name - write patient's name in boxes, one letter per box.
5. Appointment record - This space is provided to assist the case monitor in following-up on client's treatment plan. The comments section should be used to indicate outcome of appointments made.
6. Narrative summary of follow-up - This space is to be used to record information concerning treatment received. Such information will assist in completing the following question (item #7). NOTE: Either #7 or #9 will be completed, but not both.
7. Problem status - to be filled in upon problem completion or 180 days from initial date of referral. Check appropriate box. NOTE: Item b is to be checked when the problem is cured or inactive, but more than one visit was necessary to achieve this status. Item c applies if treatment plan is terminated, but the condition cannot be considered cured or inactive.
8. Method of follow-up - Check appropriate box. If various methods were used in follow-up, indicate which method resulted in the most information.
9. Reasons for inability to complete problem - If treatment cannot be completed for non-medical reasons, check appropriate item.
10. Date form completed - enter date.
11. DPW worker signature - sign.

9. Diagnosis - This item is optional but would provide needed information on the results of screening and treatment. If more space is required, an additional sheet of paper should be attached.

10. Source of documentation - Check the type of source of information for this form. Examples of other sources are medical receptionist, medicaid office clerk, nurse, etc.

11. Reason for non-completion of referral-treatment process - Check appropriate box and explain reason that necessitates closure of services if appropriate. Check client unlocatable or no longer eligible if appropriate. NOTE: Item #11 does not apply if items 4 through 10 were completed.

12. DPW Worker/Agency Representative - Print name of person executing the form and DPW BJN.

    Signature - Worker or representative signs Form 402-S.

    Date - Enter date information was obtained.

Entry Instructions - Individual Work Sheet

1. Week of _____

   Indicate the weekly period covered by the report - (Monday through Sunday), i.e., March 10 - 16, 1975.

2. Name of Employee

   Indicate full name

3. Job Title and Job Title Number Code

   The job title entered must be one of 24 contained in the category of personnel section of the Cost Data Summary Sheet (page 27) or identify with one of these 24 by the code number indicated on the Cost Data Summary Sheet. This correlation is imperative to ready conversion of individual work sheet data to summary sheet data. If there is difficulty in fitting a job title to one of these classifications, Job Title Code Number 24 may be used, which is "Other (specify) _____".

4. Activity of Assignment

   The activity of assignment must be one of the eight "Major Project Functional Activities" contained in the Cost Data Summary Sheet, i.e., (1) Case-finding, (2) Screening, (3) Diagnosis and Treatment (4) Case-monitoring, (5) Health Education, (6) Other Experimental Activities, (7) Orientation/Staff Training/Staff Conferences and (8) Managerial and other Administrative Activity. This correlation is imperative to ready conversion of individual work sheet data to summary sheet data. If the "Other Experimental Activity" option is utilized to account for time, this activity (or activities) must be identified, e.g., "development of a learning disabilities screening sheet". Case monitoring activities must be broken down into two subdivisions, i.e., Problem Completion and Screen Completion. Case finding must be broken down into case finding (new cases) and rescreens. The total hours recorded in these subdivisions

should equal the entry for Case Monitoring as a whole (for each day of the week).

5. Total Hours Available this Week

The entry will be the number of hours for which paid, normally 40, unless a worker is a part-time employee (for a specified number of hours, i.e., 20 hours), or it is the number of hours actually worked by a volunteer worker.

6. Hours Worked, by Major Activity

(1) Days of the Week

The total of hours for each day will normally be eight unless one of the exception categories indicated in No. 5, above, applies. The total of daily hours will be accounted for by major activity. Any non-productive time (sick leave, vacation, compensatory time, substitute leave, etc.) should be reported in a footnote.

(2) Total Hours Worked

Based upon stipulations already identified, total hours worked should usually be the same as total available hours, except when non-productive time is involved, or where overtime is involved. If paid overtime, the total hours available should be reflected to show these as additional available hours, and then the two total columns will again coincide. If unpaid overtime, the total hours worked may exceed the total hours available but all time must be distributed by major activity. Unpaid overtime will tend to distort true costs if extensively utilized. Under such conditions a cost would have to be allocated and charged for such overtime hours.

CHAPTER VI
THE PROJECT IN PERSPECTIVE
(History - To Date)

The National Scene

The concentration of SRS demonstration activities on urban centers in 1975, in which time frame the Dallas project was conceptualized, was determined by the fact that 64% of all program eligible children in the United States were located in 14 of these centers. Not only was client participation in the EPSDT program minimal, but no governmental agency had as yet adopted the procedures to determine if children requiring treatment received it. A further element of consideration in the selection of major urban sites was the premise that if the program was to work, it must prove itself in the slums of New York, Chicago, Los Angeles, Dallas, etc.

The Texas Scene

As previously indicated, the major thrust of the Dallas project was to maximally utilize the inbeing health care system in the EPSDT program by placing the project emphasis on innovative case finding techniques that would effectively induce client participation and, if children were found to have health problems through the screening process, assure, through effective case monitoring techniques, that these children were appropriately treated.

The Medical Services Specialties Division of the Texas State Department of Public Welfare developed the coordinative base for the project throughout FY 75.

The Department of Public Welfare, with overall EPSDT program responsibility, contracts with the State Department of Health Resources to " . . . provide for the early and periodic medical screening for purpose of referral for diagnosis and treatment of all eligible individuals . . . to ascertain physical and mental defects. . . .The Texas State Department of Health further agrees to refer back to the Department of Public Welfare those eligible individuals who are screened in accordance with this provision and are found to be in need of further diagnosis and medical care." The State of Texas is unique among the states in that the Department of Public Welfare contracts separately with the State Department of Health Resources for dental services for program (Title XIX) eligible children. De facto, there are two separate programs--the medical EPSDT program and the Title XIX dental program. This fact, in itself, has many ramifications for the Dallas project, as will be addressed in these evaluations over the duration of the project.

The Dallas Area and the Project Site

Preliminary considerations were given by the State to placing the project in Houston, but later considerations settled on Dallas because of the local enthusiasm in both health and welfare agencies for the project. There were approximately 300,000 children in Texas eligible for the EPSDT program, with roughly 12% (36,000) located in Dallas County. In July, 1975, following SRS

approval of the Texas application, Special Projects Bureau of The State Department of Public Welfare was assigned responsibility for the conduct of the project. It, in conjunction with the Medical Services Specialties Division of the Department and the Dallas Regional Office of the Department of Public Welfare, devised a plan to locate the project in two of the five geographic areas for which the Dallas area had been divided for the overall EPSDT program. These two areas were covered by two DPW units for EPSDT and other Department of Public Welfare programs, e.g., dental Title XIX program, family planning, etc. These two areas were to be further subdivided into a total of four areas (see following map) for research/demonstration purposes with identification and eligible population, as follows:

SCHEMA - Sectors, Associated Zip Code Areas, Program Eligibles as Related to Total Population in Sector, and Supportive EPSDT Screening Clinics

Sector	Zip Code Area	EPSDT Program Eligibles (by Sector)	% of Sector Population EPSDT Eligible	Correlated EPSDT City Screening Clinics
A	75203 75108	8,454	7%	Lions Club Clinic
B	75216 75224		15%	Harris Center
C	75215	4,554	17.6%	Martin L. King; Spring
D	75210 75223	3,573	23.4%	Martin L. King; Spring
Total		16,581*		

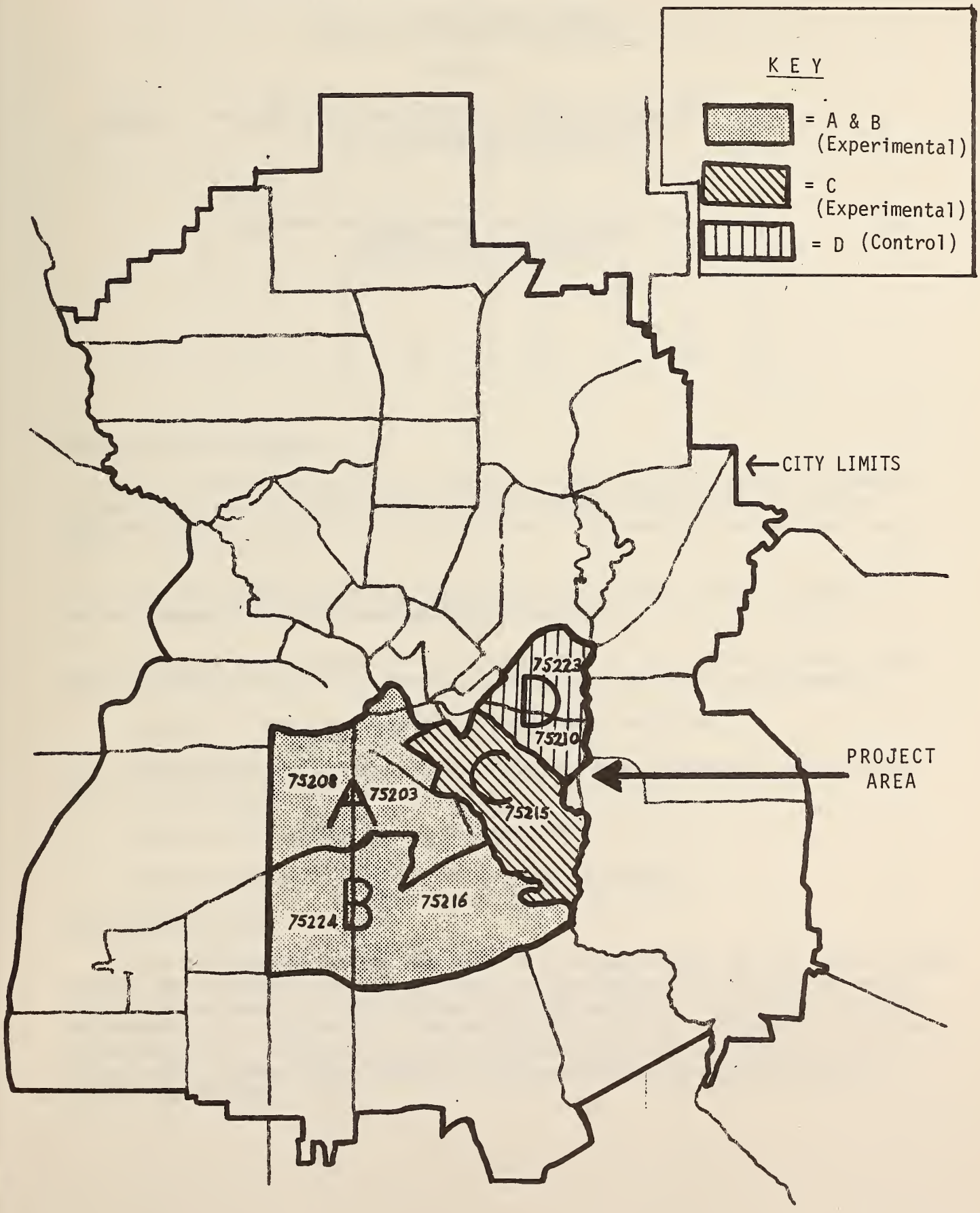
*Generally 95% black; 3% Spanish surname; 2% Anglo

Sector A, B, and C were to be utilized for experimental variation, and D as control sector (representing the "ongoing" activity).

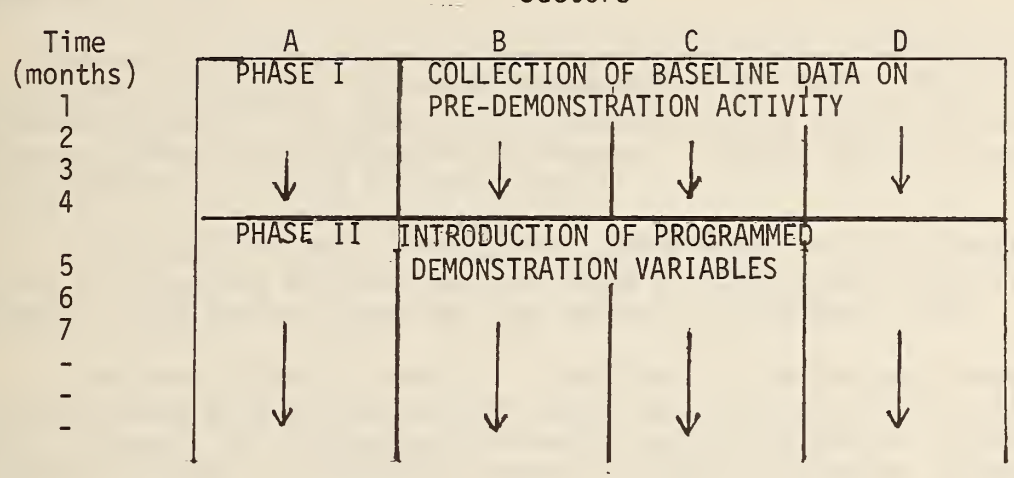
The First Year's Planned Phasing

In the initial year activities, time was planned to be utilized as follows, with month (1) intended to be any month following project approval (July) in which the project could reach such a state of case finding and case monitoring organization as to begin data collection.

CITY OF DALLAS AND EPSDT PROJECT AREAS



PROJECT PLANNED TIME PHASING



The Actual Time Phasing

As it occurred, month (1) was February, 1976, which left only five months in the fiscal year to collect data and initiate the demonstration variables. The time lag from July, 1975 through February, 1976 was attributable to a multitude of factors such as

- rewrite of the proposal by Special Projects Bureau, DPW, including revised budgets and its subsequent approval by SRS

- preparation of job descriptions in support of the revised proposal; then review, classification and approval by appropriate State personnel agencies

- posting of jobs, announcements, interviews, selection

- development and coordination of forms for data collection; then procurement and pre-testing

- training and indoctrination of personnel

- coordination and planning with the ongoing program

Start-up Activities

Since a determination had been made to hire and process all project personnel through the standard personnel structure and systems rather than as temporary short-term personnel for research/demonstration purposes, a great deal of time was expended for this purpose. The project director, Ms. Lucy Martin, was hired in October, 1975. Other key project management personnel and administration workers (case finders, case monitors, etc.) were hired during the period of November to December, 1975.

The HSRI on-site project and data coordinator, Ms. Nancy Barbas, was placed under contract by The University of Texas Health Science Center effective December 1, 1975.

HSRI and project management personnel conducted a forms pre-test in the project area during the period of December 10 - 17, 1975. Final changes were accordingly made in the forms and procurement action initiated by Special Projects Bureau during December and January. The delivery of the final printings was accomplished by late February, 1976.

A forty-hour Training Program for Case Finders and Case Monitors in EPSDT and an accompanying Workbook was developed by HSRI in the time from August to November, 1975 and was furnished the project in November, 1975.

A two-week training course was conducted by the project managerial staff in conjunction with the Dallas DPW Family Services Educational Director, Ms. Ethel B. Crear, for all project personnel during the period of January 12 through 23, 1976. This 80-hour course included instruction in the EPSDT program, preventive health care, research and research design, data collection, (concept, forms, explanation), services provided by DPW, child development, health problems of children, personnel policies, the Title XIX dental program, community resources, overview of Medicare and Medicaid, use of volunteers, case finding and case monitoring (to include extensive role playing exercises), EPSDT health screening, etc.

The appropriateness and basic necessity for all this "start-up" activity leads to the conclusion that any new project of this magnitude should include a "start-up" period of, at the absolute minimum, three months and preferably six months.

Alterations in Time Phasing

Confronted with the unalterable passage of time consuming so many months of the first year's project activity, the project director decided to by-pass Phase I (the four-month period for collection of base line data) and initiate Phase II (introduction of programmed demonstration variables) on February 2, 1976. HSRI then supported this action in modifying the research design to utilize the "control sector" as representative of the entire project area (the base).

The Programmed Research Variables (First Year's Activities)

Case Finding

The research/demonstration variables contained in the proposal for introduction at this point to assess their impact on population penetration (as measured by shows for screen) were as follows:

- Use of full time case aides as EPSDT case finders employing primarily a

face-to-face, in-the-home, contact technique.

- Use of an incentive payment to mothers ($3.00 transportation reimbursement) to bring their children to screening.

Case Monitoring

The research/demonstration variables contained in the proposal for introduction at this point to assess their impact on children who had showed for screening in terms of screening completions, problem completions, case completions, and immunization completions were as follows:

- Full time EPSDT case monitors of varying skills, i.e., Public Welfare Workers, Community Service Aides, and Public Health Nurses.

Diagrammatically, this can be depicted as follows:

RELATIONSHIP OF VARIABLES, AREA, POPULATION AND CLINICS IN THE PROJECT

	Sectors			
	A (A-J)	B (K-Z)	C	D
Zip codes	03, 08, 16, 24	03, 08, 16, 24	15	10, 23
Clients	4,227	4,227	4,554	3,573
DPW Units	I[1]	I	II[2]	II
Associated EPSDT Screening Clinics	Harris Center Lion's Club Clinic	Harris Center Lion's Club Clinic	Martin L. King Ctr Spring Clin.	Martin L. King Ctr. Spring Clinic
Case Finding Technique	Incentive (Transportation) payments ($3.)	Incentive (Transportation) payments ($3.)	Aides (Full time/ face-to-face contact)	Control
Case Monitoring Technique	Public Welfare Worker	Community Service Aide	Public Health Nurse	Control

[1]Under the supervision of Ms. Mary Powell

[2]Under the supervision of Ms. Rose Schultz

The Procedures Used for EPSDT by "Ongoing" in the Dallas Area

The ongoing activity prevailing in the Dallas area in regard to routine EPSDT case finding and case monitoring was generally as follows:

Six Family Service Units of the Department of Public Welfare in Dallas, comprising 50 workers with multiple program responsibilities, were doing EPSDT case finding and case monitoring. The method of outreach (case finding) and/or monitoring chosen by each unit was generally as prescribed by the unit supervisor. Worker effort commonly consisted of sending letters to eligible families introducing the program and subsequently arranging screening appointments by phone for those clients who responded affirmatively to the letter. They also assisted in providing transportation to the clinic with occasional home visits. A minimal amount of time was available for follow-up to treatment of children with problems found in screening.

Prior to the project starting in the Dallas area, it is estimated* that these efforts utilized ongoing case worker time, as follows:

Case finding
- 40% letter preparation and dispatch
- 30% phone follow-up
- 10% transportation for clients
- 10% home visits

Case monitoring
- 10% follow-up (case monitoring)

Preliminary negotiations by HSRI and project personnel with representatives of the Texas State Departments of Public Welfare and Health concerning forms to be utilized in the project area for data collection resulted in a dictum that newly proposed DPW, EPSDT Medical Referral (TDHR-DP 402) and Medical Referral Supplement (402-S) forms be tested in the Dallas area prior to statewide adoption. As a consequence of this action concurrently with the project initiation (February 1, 1976), not only was a new data collection form and case monitoring technique used in the project, but it was also introduced throughout the Dallas area in the ongoing EPSDT activities. This new form and accompanying procedures of necessity compelled increased ongoing attention toward case monitoring, thereby automatically reducing the differences in these activities between ongoing and the project than had been projected in the original project proposal to the Social and Rehabilitation Service, DHEW. As a consequence, ongoing worker activity during the period of February through June, 1976 (this report period) developed into the following (and current) estimated commitment of time:

Case finding
- 30% letter preparation and dispatch
- 20% phone follow-up
- 10% transportation for clients
- 10% home visits

Case monitoring
- 30% follow-up (case monitoring)

As data is collected on worker activity in the control sector from July, 1976 onward, worker time commitments will be appropriately documented.

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*Without Phase I to establish a data base of ongoing pre-project EPSDT activity, this could not be documented.

The Cost and Effectiveness Comparisons

The project effort was, in the main, to endeavor to ascertain (1) whether the full time EPSDT case finders doing almost exclusively in-the-home, face-to-face contacts, and the payment of an incentive transportation fee to clients could demonstrate significantly improved and cost beneficial rates of "shows for screen" of the eligible population (penetration rate) in respect to each other (each technique) and over that being accomplished by the ongoing activity as represented by Sector D--the control; and (2) whether full time case monitors of varying skills using essentially the same techniques could achieve significantly increased (and cost beneficial) rates of treatment and screening completions in respect to each other and over that being accomplished by the ongoing, as represented by Sector D--the control. Correlated objectives involved were to determine task performance standards (work level yardsticks) for case finders and the lowest skill level at which effective case monitoring related rates could be achieved (screen completions, problem completions, etc.)

Health Screening in Dallas

The health screening process itself, in Dallas, is carried out under subcontract by the City of Dallas Department of Health. A nine member Health Department screening team, headed by registered nurse screeners, under the direction of Nancy White, M.D., works at a different location (a series of scheduled fixed sites) within the city each weekday. As previously indicated, four of these sites (Harris Center, Martin Luther King Center, Spring Clinic, and the Lions Club Clinic) are located in and support the project area eligible population.

Pre-project conferences between the State Department of Public Welfare (EPSDT Program Coordinator, Mr. Ray Kruger) and the State Department of Health Resources (Dr. William Brumage) had elicited a verbal understanding that, if the project generated a requirement (as reflected in an increasing rate of shows for screen) for increased capacity, the Health Department would provide such capacity. In the same vein but another context, it was agreed that screening capacity must not be allowed to constrain the case finding effort as this would distort results in the case finding area.

The Project's First Year Funding

The first year's funding (July 1, 1975 to June 30, 1976), including evaluation for the project, was approved by SRS for a total of $295,915.

The Project's Initial Staffing and Organization

The project staff was generally configured as follows:

Project management	11
Demonstration workers	10
	21

The position classifications associated with these authorized manpower spaces were as follows:

Project Management

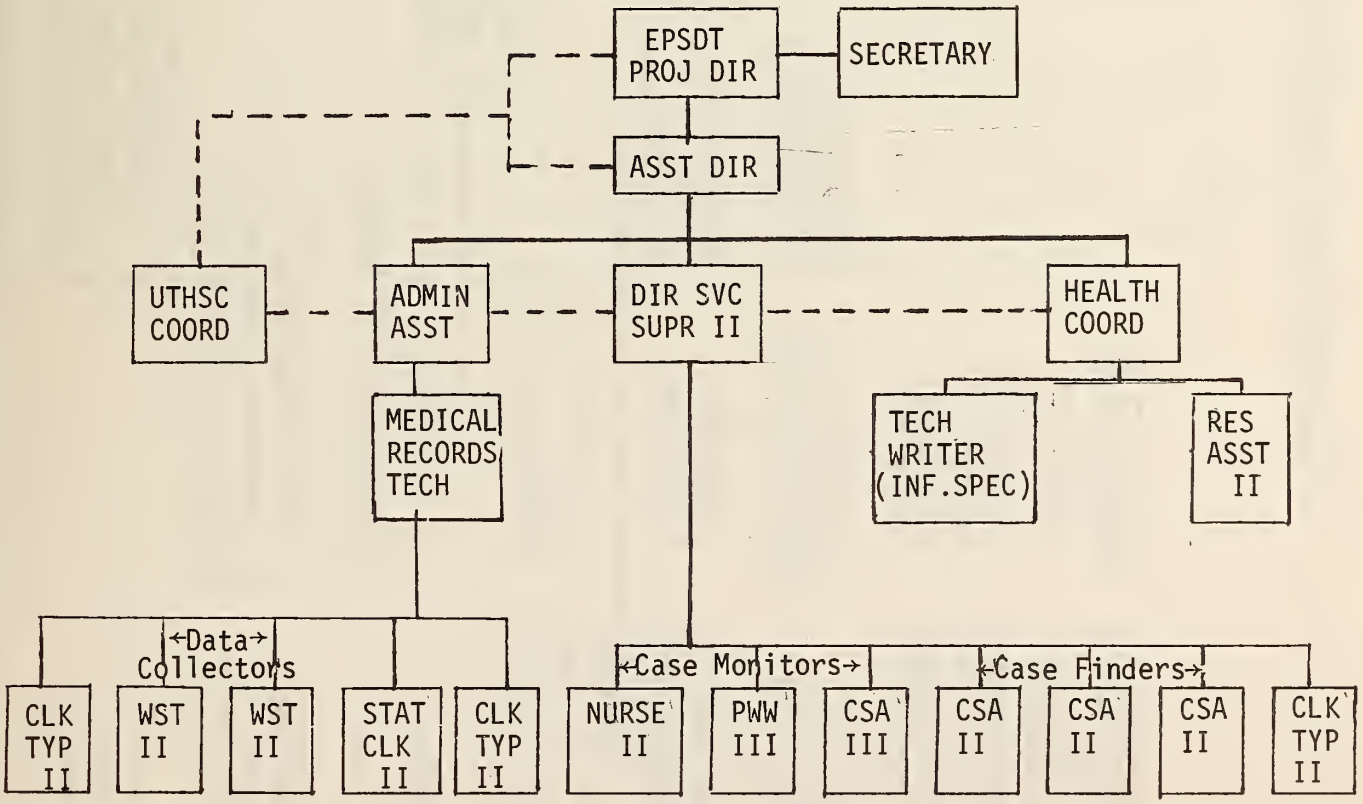
1. Project Director
2. Assistant Director
3. Secretary
4. Administrative Assistant
5. Health Coordinator
6. Information Specialist
7. Research Assistant
8. Medical Record Technician
9. Statistical Clerk
10 - 11. Clerk-typists (2)

Demonstration Workers

1. Project Worker Supervisor
2 - 3. Data Collectors (2)
4. Case Monitor (R.N.)
5. Case Monitor (P.W.W. III)
6. Case Monitor (C.S.A. III)
7, 8, 9. Case Finders (3)
10. Clerk-typist

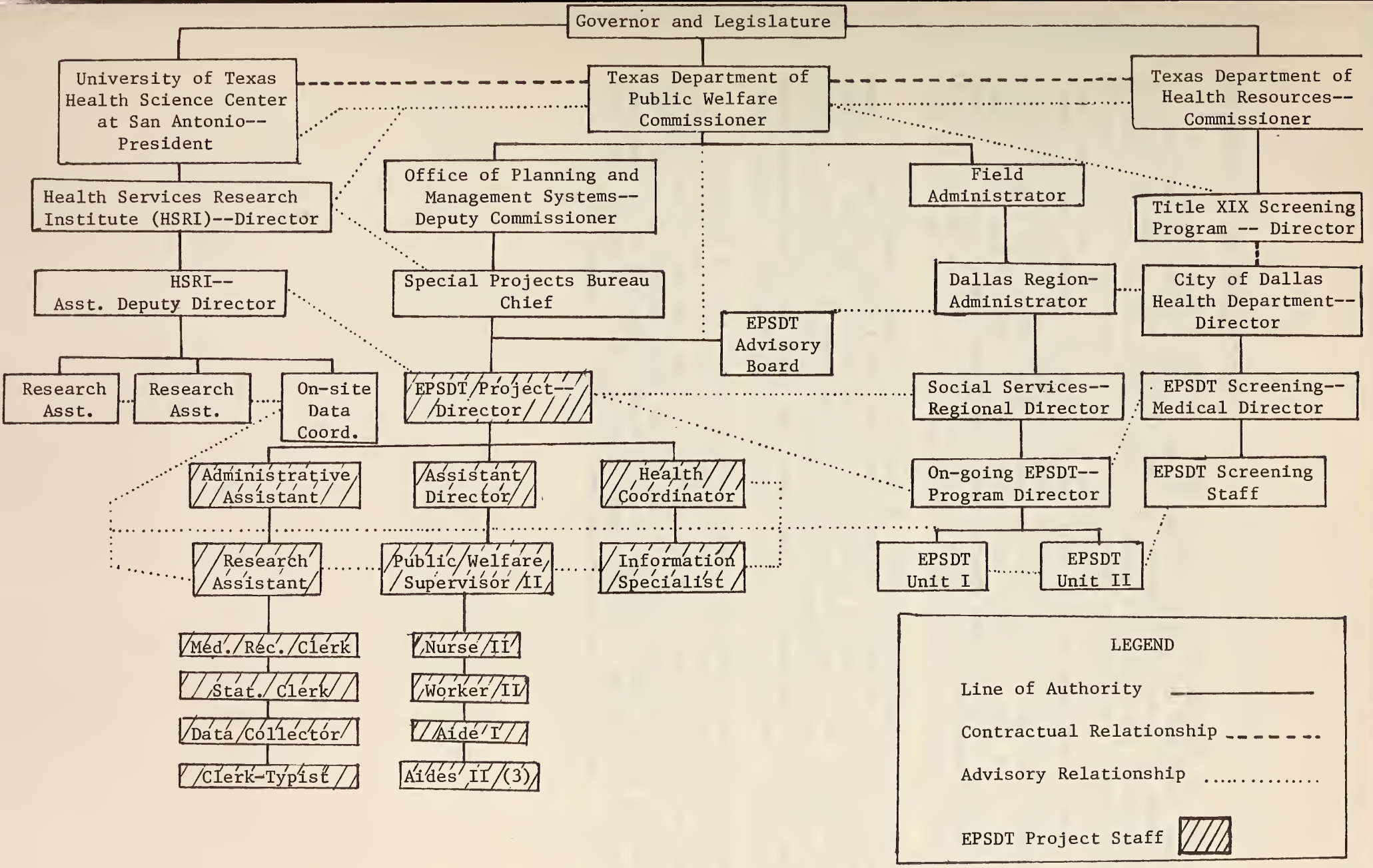
Organizationally, these personnel were structured as follows, to accomplish the project mission:

PROJECT INTERNAL ORGANIZATION



The Project and Its External Relationships

The external relationship of the project to other State and local agencies, advisory groups, and the Health Services Research Institute are reflected on the following chart:



EPSDT/URBAN PROJECT ORGANIZATION CHART

Changes in First Year Variables

At a meeting held in Dallas at the project site on December 18, 1975 between the SRS Project Officer, the Project Director, and the Chief, Special Projects Bureau, the decision was made to eliminate the incentive payment (transportation) of $3.00 case finding variable intended to be implemented in Sectors A & B. The intent of this variable was to determine, primarily from a cost perspective, the rate of client participation that could be achieved by a nominal direct payment incentive to the client with an absolute minimum of structured supportive overhead as compared to the rate of client participation achieved by a structured organizational approach with its inherent overhead costs. This was the A/B vs C and D comparison (schema on page 6). It appears that this variable was considered to have severe adverse public relations potential in the Dallas area, with possible national level reverberations and, on this basis, was deleted by full agreement of the parties involved in the meeting.

At a subsequent meeting on January 6, 1976 with representatives of the Medical Services Specialties Division, TDPW (Mr. Ray Kruger), Special Projects Bureau of TDPW (Dr. Alton Ashworth), the Project Director, and HSRI representatives, discussion of substitution variables took place. The alternative considered was to use as case finders college students in undergraduate social work programs requiring field work experience as a component of their course requirements. This case finding variable was to be introduced in Sector B.

Discussion in this instance also revealed that normal public supported transportation was generally no longer available in the Dallas area for support of EPSDT activities as a result of State cost saving activities. Since the requirement of transportation for successful case finding in EPSDT is generally accepted, it was decided to demonstrate its impact on case finding by making it available in one sector as a project funded service. The case finding design at this point (January 6, 1976) for implementation was as follows:

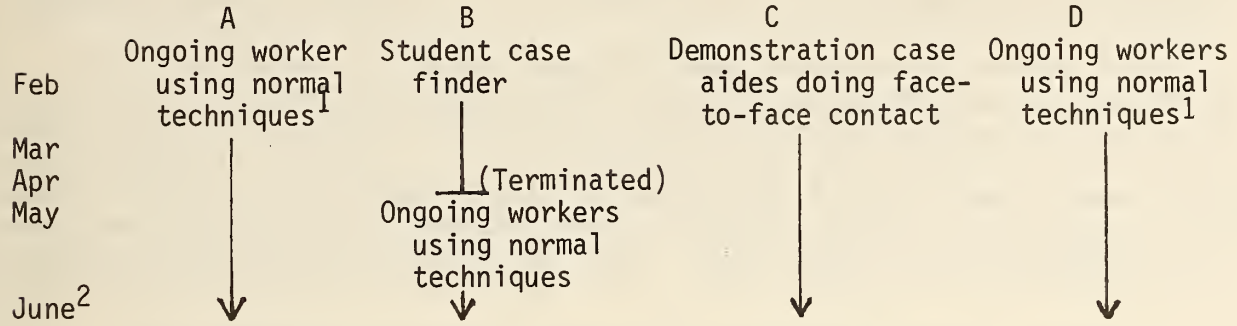
PROJECT EXPERIMENTAL CONFIGURATION FOR CASE FINDING (JANUARY 1976)

Sectors

	A (Experimental)	B (Experimental)	C (Experimental)	D (Control)
I	Case Finders	Case Finders	Case Finders	Case Finders
	Ongoing case workers (Standard technique) (Assigned group of eligibles)	Student case aides (Home visit; face-to-face contact) (Assigned group of eligibles)	Demonstration case aides (Home visit face-to-face contact) (Assigned group of eligibles)	Ongoing case workers (Standard techniques) (Assigned group of eligibles)
II	Transportation	Transportation	Transportation	Transportation
	Taxi transportation	None	None	None
III	Spec. Consideration	Spec. Consider.	Spec. Consider.	Spec. Consider.
	Ongoing caseworkers use project Family Contact Form	Student aides use project Family Contact Form	Case aides use project Family Contact Form	Ongoing case workers use project Family Contact Form
	Ongoing case workers make a special "pitch" on availability of taxi transportation to screening	Student aides are paid $3.00 for for each child they bring to screening	Case aides function as case finders under the same operating configuration as case workers in Sector D	Case workers function as case finders under the same operating configuration as case aides in Sector C

Efforts to achieve a "taxi" contract in support of Sector A did not come to fruition. As a consequence, the "de facto" variable structure in case finding for the five months of this report period was:

PROJECT REVISED EXPERIMENTAL CONFIGURATION FOR CASE FINDING



[1]30% letter contact; 20% telephone follow-up; 20% home visits and transportation; 30% case monitoring

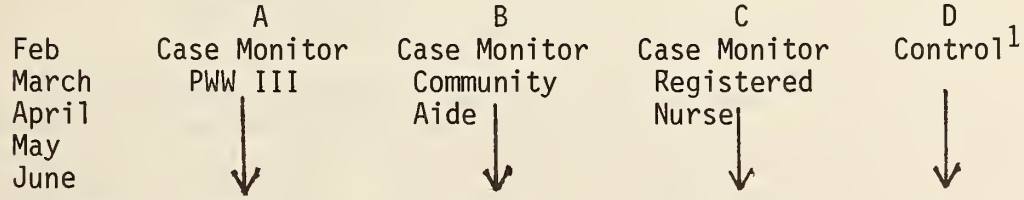
[2]A new transportation contract was let on June 1, 1976 for the Dallas region as a whole. Therefore, effective that date, routine transportation support for Title XIX eligibles again became available.

The "de facto" schema represented a vast effort devoted to Control (Sectors A, D and two months of B) with only variable contrast represented by Sector C, and three months of Sector B.

The limitations of this approach were recognized and definitive actions taken to strengthen the design for the following year of the project, which will be addressed in the next evaluation report (No. 2).

The case monitoring pattern remained unaltered throughout the period, i.e.,

PROJECT EXPERIMENTAL CONFIGURATION FOR CASE MONITORING



[1]The ongoing activity representing minimal case monitoring activity (30% estimated)

Changes in Organizational Relationships and Population Base (N) Affecting the First Year's Design

The major problem confronting this project during its first year (this report period) was developing an acceptable and workable relationship with the ongoing program. The fact that a workable solution was not achieved until the very end of this period (to be implemented at the beginning of the second year) distorted the purity and adequacy of the data being collected for this report

in many areas of project activity. This will be identified in the chapter dealing with the data analysis of the case finding and case monitoring variables.

The fundamental problem in organizational relationship emerged from the fact that in the initial concept, the ongoing program personnel in the Dallas Region were to supervise the project. The Project Director was to report to the DPW Regional Director. In this context the first design envisioned components of the program (geographical or population) being divided between ongoing and demonstration with added demonstration workers (EPSDT case finders and case monitors) being funded through the grant. This design may be schematically depicted as follows:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(Original Version)

	Sectors			
	A	B	C	D
No. of Eligibles	4,500	4,500	5,000	3,500
Sector Role	Exper	Exper	Exper	Control
	Demonstration (Project) case finders/ case monitors			(Ongoing)
	Ongoing personnel are reassigned to other areas of the city or remain in sector* but disassociate from EPSDT. *For family planning, dental program, etc.			Complete certain demo. forms and operation coordinated with demo. to program changes in procedures.

As previously mentioned, the State level supervision of the project was changed from the Medical Services Specialty Division, DPW to Special Projects Bureau, DPW in July, 1975. The project was then revised and resubmitted to SRS for approval as modified. This revision placed the project under the direct supervision of Special Projects Bureau and, in a sense, established a coordinative relationship between ongoing and the project in the Dallas area. Additionally, the project was replanned to use some ongoing personnel in a demonstration role. Without the necessary leverage, however, with respect to ongoing, the required coordination between ongoing and project became increasingly nonproductive during the period covered by this report. Since, under these arrangements, it became necessary to delineate between ongoing and project case finding activities in the designated demonstration sectors, efforts were initiated to apportion the eligible population (16,581) in the area. In the first instance (February 1 - 28, 1976) one-tenth[1] of the eligibles were considered

[1]Those eligibles whose Medicaid number ended with the digit "5".

project and nine-tenths ongoing. This apportionment, of necessity, continued and the following table reflects the status of the eligible population between project and ongoing for the period of this report.

APPORTIONMENT OF PROGRAM ELIGIBLES BETWEEN ONGOING AND PROJECT
(February/June, 1976)

Period	Last Digit of Medicaid Number	Project Population*	Ongoing Population*
Feb.1-28	5	1,658 (10%)	14,923 (90%)
Mar.1-April 21	5 & 9	3,316 (20%)	13,265 (80%)
Apr.22-June 30 (and current)	3, 5, 7 & 9	6,632 (40%)	9,949 (60%)

*Predicated upon the proposal's eligible population base of 16,581.

The major context of change in the project design resulting from this activity was to convert from N (16,581 population) to n (6,632 sample). One other factor also bears significantly on this point and that is the overall decline in welfare eligibles that took place nationwide as well as in Texas, over the period from the point of project application to the end of this report period. The latest total of eligibles in the project area is now (June, 1976) approximately 14,500. In this status, the project eligibles (n) will probably stabilize at approximately 5,800. This sample is, however, still considered to be fully sufficient to validly test the hypotheses contained in the proposal.

Though the client eligibles became appropriately categorized in terms of "ongoing" and "demonstration", the fact that the project was still depending upon ongoing workers for part of their case finding efforts (in Sectors A and B) as well as the fact that the project could not maintain adequate constraints upon the ongoing control workers and their procedural activities, the project staff and the evaluators were unable to stabilize the research design and activities so as to assure the validity of the output data.

Two major administrative/managerial actions were taken by the Chief of Special Projects Bureau and the Project Director in the time frame of March - June, 1976 to bring this situation under control. First was an action to place all workers and activities in the project areas (including the two DPW Social Service Units) under the control of the Project Director. This proposal, which is graphically depicted as follows, was rejected by top levels of management in the Texas State Department of Public Welfare:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(A Revised Proposal)

Sectors			
A	B	C	D
4,500	4,500	5,000	3,500
EXPER	EXPER	EXPER	CONTROL
DPW Unit I*		DPW Unit II*	
Ongoing and demonstration are all under project management control for EPSDT**		Ongoing and demonstration are all under project management for EPSDT**	

*Two of the six DPW Family Service Units serving the Dallas area (page 6 for additional discussion)

**Would also have probably included family planning, dental program, etc.

In this configuration the State would continue to fund the ongoing activities and the grant, the project (demonstration) activities.

In the meantime the "de facto" configuration for case finding evolved into the following schema toward the end of this report period:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(The De Facto Configuration - June, 1976)

	Sectors			
	A	B	C	D
No. of eligibles	4,500	4,500	5,000	3,500
Sector role	EXPER	EXPER	EXPER	CONTROL
	DPW Unit I		DPW Unit II	
	DPW unit splits its workers into a project support group and ongoing activities group Ongoing activities work: All eligibles with Medicaid #s ending with 0,1,2,4,6 & 8 (5,400) Project support group work: 3,5,7 & 9 (3,600)		DPW unit splits its activities to allow project workers in Sector C - case finding responsibilities for 3, 5, 7 & 9. Otherwise ongoing activity has full responsibility for 1,2, 4,6,8 & C and all eligibles in D (0,1,2,3,4,5,6,7,8,9) Project : 3,5,7 & 9 (2,000)	(6,500)

This configuration may have woked if an ideal type cooperation could have been developed between the project and the ongoing activities. In the real world, however, the arrangement was fraught with frustration for both the ongoing supervisors and the Project Director. Both groups of supervisors were serving different ends and it was inevitable that this arrangement would fail to satisfy the disciplined activities needed to support valid output data for a satisfactory evaluation.

To more adequately satisfy the ends of "managed/disciplined/constrained" activities by ongoing, the Chief of Special Projects Branch and the Project Director, as the second major effort, entered into a formal agreement with the DPW Dallas Regional Director in May, 1976. This was an agreement as to specifically what ongoing and project would do in support of each other, but again, itstill involved ongoing workers performing demonstration (project) defined and delineated activities. Because of the inherent conflicts built into this arrangement and its impact on the data and the evaluation, and following discussions between the Chief of Special Projects, the Regional DPW Director, the Project Director and SRS Project Officer on July 1 and 2, the decision was made to discontinue the use of ongoing personnel in the demonstration activities (except to reflect the ongoing activities--control) and to fund the case finders for Sectors A and B from the grant.

The design (schematically)as the project entered the period to be covered in the second evaluation report is as follows:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(The Final Version - July 1, 1976)

Sectors			
A	B	C	D
4,500	4,500	5,000	3,500
			CONTROL
DPW Unit I		DPW Unit II	
Ongoing: 1,2,4,6,8, & 0 (Non-project)			Components of Unit II - working Sector D - must complete project forms as stipulated
EXPER Project (3,5,7 & 9) (1,800 eligibles)	EXPER Project (3,5,7 & 9) (1,800 eligible)	EXPER Project (3,5,7 & 9) (2,000 eligibles)	Operations of ongoing in Sector D must be fully coordinated with the project and changes pre-planned and fully coordinated.

This design is expected to be satisfactory in terms of meeting the objectives of the project.

Dallas EPSDT Demonstration Project

Control Sector

(Texas State Department of Public Welfare Dallas Regional Units)
December, 1976

Prepared by:
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Enclosure 1

Table of Contents

INTRODUCTION

This report is to serve as a description of the outreach and follow up service delivery methodology of the regional EPSDT units designated as the control sector in the Dallas EPSDT Demonstration Project. The control sector is geographically adjacent to the project areas under experimental study and consits of zip codes 75210 and 75223. Two Department of Public Welfare units, 13 and 50, are responsible for EPSDT provision in this area. Designation of project sample control cases and specific control worker case assignment was finalized November 1, 1976. Based on the number of sample cases (approximately 40% of the area eligibles) a decision was made to assign two workers from the regional units to work with sample control cases only. Control data for the Dallas EPSDT Demonstration Project is generated from the performance and activities of these two workers. It is assumed that their methods and outcomes are representative of the regional program units in which they work. The sections of this report on Staff and Outreach Follow-up Methodologies in particular focus in on these two workers.

STRUCTURE

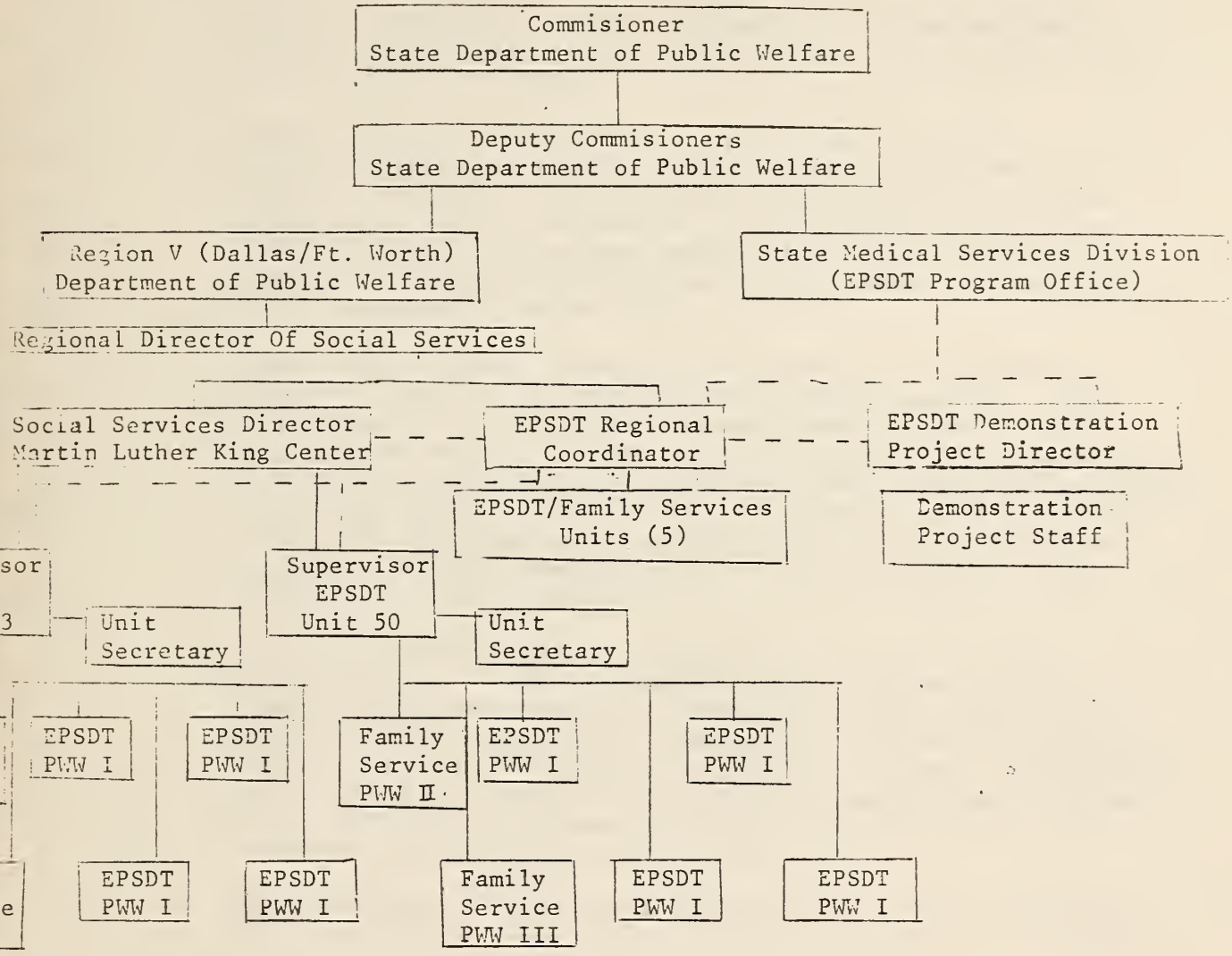
The Texas EPSDT program is managed under the State Office of Medical Services Specialties. Each state DPW region has designated an EPSDT Coordinator who oversees regional organization for delivery of services and reports to the Medical Services Division. The organization for services delivery in the Da-las region currently consists of geographic assignments to 7 DPW units responsible for delivery of both EPSDT and Family Services. The two units assigned the control sector, 13 and 50, are housed in the Martin Luther King Community Center. In the city of Dallas the Director of Socail Services at the Martin Luther King Community Center retains responsibilities for these two EPSDT units.

Each unit consits of a supervisor, a specifically allocated number of Family Service Workers, a specifically allocated number of EPSDT workers and clerical support staff. Units 13 and 50 each have four EPSDT workers. The organizational chart illustrated the alignemnt of the regional units with respect to the state EPSDT program and further details worker alignment in the control sector units.

Policy statements, program guidelines and goals are established in the State Medical Services Division. A technical manual, most recently revised for use as of September, 1976, is available to all local operators. The control sector units reportedly adhere closely to the manual and to additional technical assistance memos which are generated from the State office.

Minimum goals for the number of eligible clients receiving EPSDT services are established by the Medical Services Division at about one-half the populations of eligibles per region for medical and a slightly smaller portion for dental (FY 1977). These goals transtate into some smaller proportion for each worker dependant on the geographic area of assignment and the individual units's work force. The control sector workers have been assigned the goal of 45 medical screens per month.

ORGANIZATIONAL CHART



Key

_____ Direct Supervision

---------- Coordination and Technical Support

DEFINITION OF SERVICES

Each worker is responsible for both outreach and follow-up in the EPSDT program. The areas and scope of their responsibility is as follows.

1. Medical Screening: Workers must inform clients of the availability of medical screening examinations and appoint them to a clinic. Furthermore, workers assist clients in arranging transportation when required.

2. Medical Diagnosis and Treatment: In instances in which a screenning team refers a client for further medical attention, a worker is responsible for assisting clients acquire such care. Regulations specify that workers's responsibilities for informing clients of medical providers, making appointments and securing transportation extend to the clients firtst show for treatment but not necessarily beyond that.

3. Dental Initial Visit: Workers are responsible for informing eligible clients of the availability of dental services. They must initiate the state authorization process. Upon receipt of an authorization for services they are responsible for arranging an appointment with the dentist of the clients choice and assisting with transportation. Workers are not responsible for assisting client with appointments beyond the initial visit, though they are responsible for keeping records of dentists requests for additional treatment approval.

4. Dental Utilization Reviews: Workers assist a state team in periodic reviews of dental providers in the region. Workers are responsible for insuring that a sample of clients who have received treatment from dentists participating in medicaid attend a review clinic at which their treatment is examined. Utilization review take place throughout the year at choosen sites. The number of clients reviewed whom each unit in the research area is responsible for is estimated at 25 per month.

5. Family Planning: Workers must inform clients of the availability of family planning services and location of providers in the area.

UNIT MANAGEMENT

SUPERVISION

Each unit is managed by a unit supervisor, and individual required to have a minimum education of a bachelors degree and either an MSW or two years employment in a Socail Services Agency. The two supervisors in the control sector are, themselves, supervised by the Martin Luther King Social Services Director. A major responsibility of the supervisor is to assure worker compliance with the guidelines established by the State Medical Services Division. This task is facilitated through communications between the unit supervisors and the EPSDT Regional Coordinator. The Coordinator holds bi-monthly meetings with all unit supervisors. Unit management and compliance with guidelines encompasses the following supervisory tasks:

1. Unit meetings once per month
2. Staff supervision with each worker once per month
3. Evaluation of unit workers
4. Monitoring of client case records for content, client services received, worker activities, length of time of worker involvement. The supervisor reads all records to assure clients receive all services as outlined in the program regulations.
5. Management of case assignments
6. Regulation of personnel hiring, sick and leave time approval and travel reimbursement approval.

The control sector supervisors do not establish details of EPSDT outreach and follow-up methods, rather monitor individual workers techniques through close regulation of case records.

CASE ASSIGNMENT

The two units involved in the control sector cover the same geographic area -- zip codes 75215, 75210, and 75223. The EPSDT Demonstration Project's sample includes only those clients whose Medicaid number ends in 3, 5, 7 or 9. In zip code 15 these cases are assigned to Project employed workers and treated experimentally. In zip codes 10 and 23, as mentioned earlier, two workers employed by the regional program units are assigned sample cases (starred * in the following table). Case responsibilities for each regional unit are designated by the supervisors as follows:

EPSDT Worker	Zip Code	Last Digit of Medicaid #	Alphabetical Case Names
Unit 13:			
Public Welfare Worker I	15	0, 1, 2, 4, 6, 8	A - F
PWW I	15	0, 1, 2, 4, 6, 8	G - L
PWW I	10, 23	0, 1, 2, 4, 6, 8	A - L
* PWW I	10, 23	3, 5, 7, 9	A - L
Unit 50:			
PWW I	15	0, 1, 2, 4, 6, 8	M - T
PWW I	15	0, 1, 2, 4, 6, 8	T - Z
PWW I	10, 23	0, 1, 2, 4, 6, 8	M - Z
* PWW I	10, 23	3, 5, 7, 9	M - Z

SYSTEM CAPACITY AND UTILIZATION

The control sector, zip codes 10 and 23, contains approximately 35,000 EPSDT eligibles. The 40% sample contains approximately 1400 which, divided among two workers, totals 700 clients per worker. The Department of Public Welfare estimates 3.5 eligibles per family. Thus each worker is assiged approximately 200 client families. As of November 1976, the control workers report they have performed some type of outreach with all eligibles in the sample central sector. They are currently working with clients who were unsuccessfully outreached in the past, rescreens, and new eligibles.

RECORD KEEPING

Workers are required to perform narrative case recording for all cases indicating all worker activities performed, dates of performance and client responses. In addition, workers utilize three forms for case management: a release for medical information signed by clients, a Title XIX Summary containing condensed information the same as the narrative and problem refferal forms (State 402, 402S). Lastly, workers utilize individually developed systems of notation on the list of eligibles (708) or develop card file systems as a quick resource to learn what services have been delivered (or attempts made) foreach client.

STAFF

Both workers delivering EPSDT services in the control sector are Public Welfare Worker Is. Requirements for this position consist of a bachelors degree or 60 hours college credits plus one year employment with the department in a social service position. Both workers employed by the control units have worked for the Department of Public Welfare for over two years, one with the EPSDT program the entire time, one for six months. The salary of a Public Welfare Worker I is $876 per month.

Both workers received several weeks of orientation and training thru the DPW Training Division upon beginning work with the Department. Each worker received several days of training specifically in EPSDT. The EPSDT training consisted of an explanation of the program, instruction in "marketing EPSDT to clients" and micro-counseling.

OUTREACH AND FOLLOW-UP METHODOLOGIES

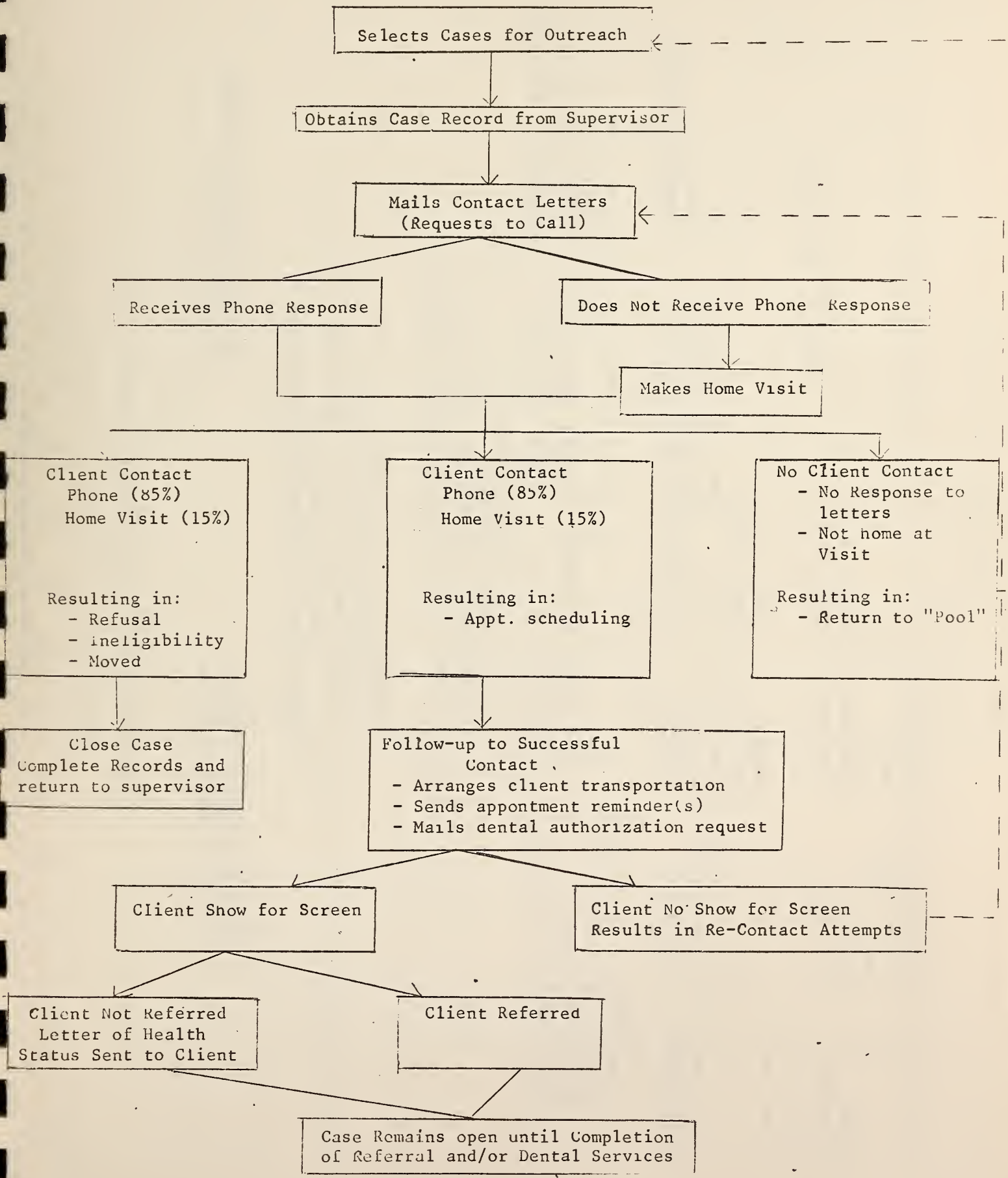
The description of methods used in EPSDT service delivery corresponds with the flow charts on the following pages. Supervisors and workers estimate that 60%-70% of worker time is spent on outreach.

OUTREACH

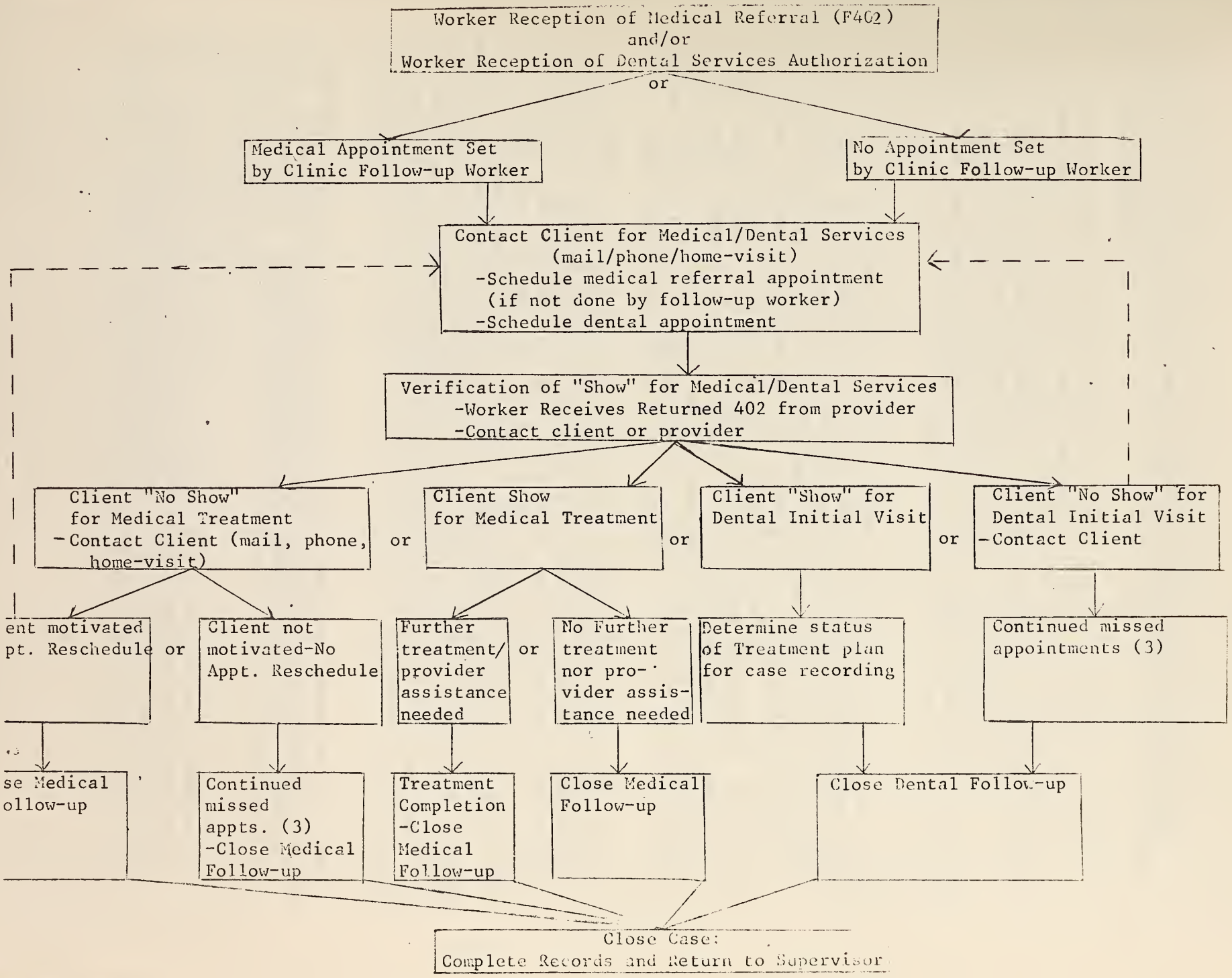
1. Selects Cases for Outreach: Each worker selects cases from his/her assigned case load as defined by the unit supervisor. A list of eligibles in a unit's jurisdiction (MP 708) is supplied by the state medical services division and available to each worker. A worker selects approximately 20 families per week whom they will outreach. After eligibility, the major basis for selection is whether a client has ever received medical screening services and if so, whether they are due for a periodic rescreen. Workers proceed and select clients as their name appears on the list, working down alphabetically.

2. Obtains Case Record: Workers obtain case records either at the time of case selection or not until a return response to a letter contact is made. Generally,

OUTREACH PROCEDURES FLOW



FOLLOW-UP PROCEDURES FLOW



if a worker intends to make intense outreach efforts, as described in 4, b below, she will obtain client records upon sending a letter and keep them until the end of that intense effort. Records are checked out and in through the unit supervisors.

3. Mails Contact Letter: Upon selection, a client is sent a letter by a worker with instructions to call the worker and perhaps a brief explanation of the EPSDT program. Workers expect approximately a 50% response to the letters. Workers develop their own approaches to letter sending, for instance in choice of form letter or personal letter which they send. One worker indicated she sends letters routinely on Fridays believing that clients curiosity is triggered on the weekend instigating them to call Monday whereas upon receiving letters in the middle of the week they tend to put off calling until Friday and often forget.

4. Phone Response: Clients usually contact workers by phone in response to letters within 5 days of their mailing. If a client does not contact the worker one of two treatments may occur: a) the clients will be considered "returned" to the "pool" of eligibles and sent a letter again when the worker returns to his/her name after proceeding through the list of eligibles. This period of lapsed outreach attempts is estimated to be a maximum of 2 months. b) The client will receive another letter by the end of the next week and furthermore, continue to be outreached immediately until a response is attained or until the worker establishes that at least three letters were sent and a home visit made without success. Home visits are regularly made to those clients who do not respond to letters regardless of the timing of the letters.

5. Client Contact: If a client requests services, appointment scheduling occurs immediately when the first direct communication between the worker and client takes place. This immediacy is facilitated by the fact that 85% or better of the direct communication is a result of clients calling a worker in her office as a response to a letter. The worker is able to determine a client's interest in participating and to call the clinic scheduling office (located at MLK Center) while the client simply holds the line. The appointment date and time is confirmed with the client right away. The client is also informed that a request for dental services will be initiated to Austin for those eligibles in the family who want the service. Furthermore, the worker inquires as to the need for transportation and will instruct a client in its use if desired during this first direct contact.

   Those fewer instances in which a client-worker communication occurs at a home visit are handled in the same fashion as over the phone, though somewhat delayed due to the need to schedule and confirm appointments often without immediate access to a phone. Clients who do not have phones receive appointment confirmations through the mail.

6. Follow-up to Appointment Setting: Reminders and transportation arrangements: The transportation system that exists places ride scheduling and organization within the responsibility of an EPSDT unit. In scheduling transportation to a clinic for a client, a worker must simply coordinate with the individual in the

unit who is assigned transportation responsibility at that time. Transportation arrangements must be made prior to 24 hours before an appointment. A van (available through contract with a private transportation company) runs more or less as a shuttle service to and from a clinic throughout the day according to the schedule coordinated through the units transportation worker. The transportation worker actually rides on the van the day of the clinic.

In addition to scheduling transportation, prior to the appointment day the worker sends a reminder letter to each scheduled client family. The worker plans client reception of the letter within three days before the clinic and will also often phone the client the day before or the day of the clinic.

7. Clinic Attendance: A worker is informed of kept and not kept appointments by the reception of clinic screening records (F400) for those who did show. The records are received from the screening team two to three weeks after the clinic. Those clients who did not keep appointments (no F400) are contacted as soon as possible. Usually this is attempted by means of a letter of inquiry requesting the client to call the worker. The worker attempts to establish the reason for the unkept appointment and determines if the client is still interested in the services. In other words, once a client has expressed interest and been scheduled for one clinic appointment, an intense effort takes place to acquire a show at the clinic. Workers contact clients be letter or phone in attempts to reschedule appointments. Home visits are regularly made to those clients who do not respond to at least three letters or those clients who have been scheduled two or three times and continue to miss appontments. A home visit is often a last effort to achieve client participation. Workers often use their own judgment to determine a client's intentions and obstacles in keeping appointments and will base decision on when to close efforts on this. The units unwritten, though agreed upon minimum level of effort, is three missed appointments before closing a case.

8. Medical Status: Those clients who keep clinic appointments are contacted appropriately depending on their status after the screen. If no referrel is made they are sent a letter of closure for medical services and the screening records. A case remains open, though, if a client has been referred and/or has requested dental services. This continued monitoring is illustrated in the second page of the flow chart.

FOLLOW-UP

9. Origination of Medical Referral (F402) and/or Reception of Dental Services Authorization: A worker usually receives a client approval for dental services about the time of their medical screening appointment (approximately three weeks after screening appointment is scheduled and dental request submitted). Therefore, medical referrals and dental services requests are usually handled simultaneously.

10. Client Contact for Medical and/or Dental Services: Appointments for referrels with medical providers in the community are made in one of two ways depending on the nature of the problem. If the need for referrel was determined at the

clinic, a referrel form (F402) is originated by a nurse. An assigned worker from the EPSDT unit is responsible for assisting clients schedule appointments with providers and acquiring transportation before the client leaves the screening clinic. The worker who originally scheduled the client for the screening will receive a copy of the F402 within the week and will provide further assistance, such as sending appointment reminders. Or, if the referrel is not originated until the results of lab tests have been received (two to three weeks subsequent to the clinic) the original worker receives the F402 and performs all client contact and provider appointment scheduling procedures. Again, as in outreach, a worker will send at least three letter and make at least one home visit in attempts to contact client for referral appointment scheduling. Workers indicated that their usual provider resource is Childrens Medical Center unless other requests are made. Appointing for dental services entails the same three letter attempts at contact as in medical follow-up, though a home visit for dental scheduling when no medical referral exists is often eliminated. At the time of appointment setting workers establish a client's transportation needs. Subsequent to appointment setting, a worker often sends clients a reminder letter and arranges transportation if needed. In few instances a worker will provide transportation herself.

11. Verification of show for treatment: A worker receives information concerning kept referrel appointments by receiving a returned copy of the referrel form from the provider, calling the provider or communicating with the client. Verification of dental appointments is most often done through the dentist.

12. Appointment attendance: When a client shows for medical treatment, the worker determines whether further follow up is needed and whether the provider requires assistance in coordinations with the client. If a provider does request assistance for further treatment the worker will continue to intervene. If the provider does not request assistance, whether or not further treatment is required, the worker will close the case to medical follow-up.

Those clients who do not keep their original medical referral appointment are contacted by the worker through a better requesting a return call, through a direct call, or on a home visit. The worker interprets the client's desire to seek diagnosis or treatment basing the interpretation on reasons for missed appointments. A worker may reschedule missed appointments as many as two times. If the worker judges the client to be unmotivated in seeking care (perhaps lacks reason for missed appointment, refuses further care, misses three appointments) the worker will inform the client that she may contact her if she changes her mind but will formally close the case.

In most instances workers obtain information concerning kept and unkept dental appointments from the dentists receptionists. Workers will schedule clients a maximum of three appointments in attempts to obtain a show for treatment. Again, unless simultaneous work is being performed for a client medical referral, a home visit will not likely be made. If a client does not keep three appointments the worker will inform her that she may call the worker if she desires help in the future but will formally close the case.

13. Continued referral monitoring: A worker will continue to monitor a clients

treatment as long as the provider requests assistance and the client does not refuse nor miss more then three consecutive appointments. A case is closed if any of the three above situations are not met or when treatment is completed. Workers do not ordinarily monitor dental treatment plans. They are required by their supervisor, only to record in the case record whether a dentist submitted a treatment plan to the state.

14. Case closure: When both medical and dental outreach and follow-up is completed a case is closed until the time due for a periodic rescreen, or until a client initiates a request for further services herself. All recording is performed and the record returned to the unit supervisor. To summarize, the following conditiions indicate completed action on a case:

Medical Screening, Diagnosis and Treatment -

a) Client Refusal for medical screening services.
b) Client failure to keep at least three appointments.
c) Client show for screen resulting in no referrals.
d) Client show for screen and for follow-up
e) Client show for screen and for follow-up on referral appointment with further treatment required but no worker assistance requested by provider.
f) Client show for screen but unable to contact after numerous attempts to set referral appointment.
g) Client show for screen and referral with failure to keep at least three referral appointments.
h) Client show for screen, and show for referral appointment, monitored until problem completion.

Dental Initial Visit and Treatment

a) Refusal for dental services
b) Client failure to keep at least three dental appointments
c) Client show for dental initial visit and establishment of whether a treatment plan is submitted.

A client to whom outreach attempts were made but who the worker failed to contact after numerous efforts will very likely be outreached again within the year.

SUPPORT SERVICES

Within the Department of Public Welfare, the EPSDT unit is highly dependant on the technical assistance and policies of the Medical Services Division. Also, the Continuing Education Division is responsible for all training provided to EPSDT unit workers - the state office for producing training manuals, the regional office for conducting training sessions.

Close coordination efforts exist directly between the unit supervisors, workers and the contracted Medical Transportation Company.

Screening services are provided through a regional DPW contract with the Dallas City Health Department.

The workers retain major responsibility for establishing the availability of medical diagnosis and treatment providers. The control sector workers estimate that 80% of their referred clients are sent to Children's Medical Center. In addition several MD's who practice in their target area are used when clients prefer a private doctor or closer service availability. Several optical clinics exist in the area but are used minimally whereas an optician practicing in the area is referred to regularly for vision problems.

Workers have access to a list of dental providers in the area. A worker often develops a working relationship with a dental provider or his staff in order to facilitate close communication concerning the status of clients treatment.

Information and referral needs of a client other than for EPSDT or medically related are commonly handled by the Family Services Worker who is assigned to the same unit as the EPSDT worker handling the case. (See Organizational Chart.) The accessibility of the Family Services Staff worker provides a well-defined mode of referral action for a EPSDT worker to rely on. One control worker indicated that she often handles Family Services requests and referrals from her EPSDT clients herself due to her knowledge and past experience with Family Services responsibilities.

Dallas EPSDT Demonstration Project

CASE MONITORING

February through December, 1976

Prepared by:
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January, 1977

Enclosure 2

Table of Contents

INTRODUCTION

The Dallas EPSDT Demonstration Project has experimented with one major variable in the case monitoring subsystem during the first eleven months. The Project is examining how varying the level and type of case monitor influences cost effectiveness in the follow-up process. The proposal for the first year of the Project states the following concerning the use of different monitors in the research design.

> Sector A: One additional Public Welfare Worker will be assigned to talk with parents and help them understand the need for diagnosis and treatment, using classical social work techniques.
>
> Sector B: One Community Service Aide will be assigned to talk with parents and help them understand the need for diagnosis and treatment, using techniques developed in the special training course and the better communication of an indigenous person.
>
> Sector C: One public health nurse will be assigned to talk with parents and help them understand the need for diagnosis and treatment using classical public health techniques.

This geographic assignment has been implemented from February thru September 1976. In October, the Public Health Nurses position was phased out and replaced by a Welfare Service Technician in Sector C.

This report will serve as a description of procedures used in the case monitoring subsystem during this period. Included are descriptions of system organization and management, follow-up processes, and techniques specific to each type of worker. In addition to level of worker, several changes in system procedure took place during the period which should be noted. Success rates for workers are not discussed here though strengths and weaknesses in performance which were observed by monitors, the unit supervisor and Project Director are reported.

STAFF PROFILES

SOCIAL WORKER

1. Qualifications

Qualification requirements for the position of Social Work Monitor (State Department of Public Welfare Worker III) included minimum education of a bachelors degree and either a Masters in Social Work or two years social service work experience. The position in the project was originally filled by an individual who had been employed as a social worker for three and one half years by the Department of Public Welfare. This individual had one and one-half years experience working in Family Service and peripherally in EPSDT. Six months of this employment she was assigned specific responsibility for follow-up activities. Furthermore, the geographic area to which she was assigned prior to her Project employment encompassed some of the same area as her project assignment.

The second Social Worker who filled this position had previously been employed by the Department in the Food Stamp program for two years at a lower pay scale (State Department of Public Welfare Worker I). Employment by the Project was her first experience in EPSDT.

2. Social Workers received $936.00 per month.

3. Training

No formal training for the position of Social Work Case Monitor was received by either social worker during employment with the EPSDT Demonstration Project. Both attended Department of Public Welfare orientation in 1973 and 1974 respectively. Their EPSDT training consisted of informal instruction from Project supervisory staff on basic EPSDT responsibilities and description of the demonstration project. To summarize, the social workers were dependent on experience within the Department of Public Welfare rather than formal training in the performance of responsibilities in the project.

4. Turnover Rates

The Social Work position was filled Febuary 1. (It should be noted that this date is subsequent to completion of the project staff training program which took place in January.) The same individual remained in this position until September first at which time termination took place to pursue educational advancement. Due to DPW personnel policies, a replacement did not begin work until October 1, leaving the position vacant during September. The second social worker has been in the position since that time.

COMMUNITY SERVICE AIDE

1. Qualifications

The position of Community Service Aide required that an individual have at least a high school education and live within the geographic area which included the demonstration projects' target population. The in-

dividual first employed in the Project was transferred from a clerical position in the Department of Public Welfare. Beyond a high school education she had one year of college credits and continued to attend college courses concurrent to her employment as a case monitor. A second community service Aide employed in this position had a high school education, had worked with the Welfare Department in a clerical position for three years and had worked for the EPSDT demonstration project for nine months in an outreach capacity before being promoted to Case Monitor.

2. Community Service Aides were employed at a monthly salary of $630.00 to $673.00.

3. Training
Both Community Service Aides had received orientation into DPW several years prior to employment with the Project. In January, 1976 they attended the formal two week training course specifice to EPSDT and the research project. The course was designed specifically for individuals who lacked social services and specifically EPSDT experience. Both received the same training though at the time they were preparing for different responsibilities. (Further detail on the course can be found in the manual - "Training Program for Case Finders and Case Monitors in EPSDT" prepared by HSRI .)

4. Turnover Rate
This position was filled by one individual from January through September, 1976. As of October 1 this individual was promoted to the position of Welfare Service Technician with the same responsibilities. The position was vacant during October. In November, ar employee who occupied a position of case-finder in the Project was promoted to Community Service Aide case monitor.

PUBLIC HEALTH NURSE

1. Qualifications
Requirements for filling the position of the Public Health Nurse performing case monitoring activities included qualification as a Registered Nurse and a minimum of one year experience in a Public Health setting. Hiring for this position was difficult for several reasons: 1) The Department of Public Welfare had limited access to applicants for a position so closely related to the health system and 2) several applicants who were interviewed were not attracted to the position due to the lack of direct nursing practice in the job description. After approximately a month and a half, an R.N. was hired who fell slightly short of meeting the job requirements due to the more limited than desirable public health experience she had as a student intern. Her previous professional work experience consisted of approximately one and one-half years hospital nursing.

2. A monthly salary of $1,000.00 was paid to the nurse, until September at which time her monthly salary was raised to $1,068.00.

3. Training
During the first month of her employment, the nurse attended a three day orientation with the Department of Public Welfare. No formal training in

EPSDT was received. Instructions on job responsibilities were given on an informal basis by the direct services supervisor. Also, the nurse experienced a breaking in-period in which she was accompanied and assisted by the Social Work Case Monitor on her first several case assignments.

4. Turnover rates
The Nurse Case Monitor began employment on March 1st. Due to the nurse's job dissatisfaction and a resultant decision on the part of Project administrative personnel, the nurse's case monitoring responsibilities began phasing out September 1st. No new cases were assigned to her since that date though she completed follow-up on all 'old' cases. Furthermore, an administrative decision has been made that substantial evidence has been collected during the months of March through this phasing out period which warranted the discontinuation of the Nurse Case Monitor position. (See Appendix A for administrative statements regarding the nurse case monitor.)

WELFARE SERVICE TECHNICIAN

1. Qualifications
The state Department of Public Welfare requires a Welfare Service Technician (II) to have a high school education plus a minimum of 60 hours college credit. As mentioned, the individual in this position was promoted from a Community Service Aide Case Monitor in the Project as she had acquired the necessary qualifications. (See description of Community Service Aide.)

2. The salary earned by a Welfare Service Technician ranges from $794 to $820 per month.

3. Training
The Welfare Service Technician received no additional EPSDT training after her promotion and her responsibilities did not change. She had, though, earned 30 hours of college credits since she began employment with the Project in January.

4. Turnover Rates
The position of Welfare Service Technician became effective October 1, 1976. This new level of monitor was instituted to replace the discontinued Public Health Nurse position. The same individual has filled the position from October through December.

CLIENT TARGET

The population eligible to receive screening services totals approximately 4,500 to 5,000 in each sector of the research area. The 40% research sample reduces the number of eligibles to approximately 1,680 in Sector A and B and 2,000 in Sector C. Those who could be potentially included in the target population of the Case Monitoring subsystem are those eligibles who satisfy at least one of the following conditions: 1) receive screening services and are referred for diagnosis or treatment 2) require additional testing by the screening team 3) require immunizations 4) request and obtain state approval for dental services. Those requiring medical referral assistance only, equal approximately 13% of those screened based on the Dallas, Title XIX Screening Team referral rates. Therefore, the eligible population assigned to medical follow-up in the research project case monitoring subsystem is potentially 218 in each Sector A and B and 260 in Sector C. The number requesting dental services is much higher, estimated at 80% of those eligible resulting in a caseload of 1,250 to 1,350 persons in each sector. The population requiring medical follow-up and that requesting dental services overlap. The target population estimated above is a potential for the case monitoring subsystem. The monitored population is necessarily dependent on the number and type of eligibles who become involved in EPSDT through the outreach or case-finding subsystem which subsequently generates cases for the monitoring subsystem. The impact of the inter-subsystem dependency on the target population and case monitor case load will be discussed in the following section.

SERVICE DELIVERY

DEFINITION OF SERVICES

Case Monitors are responsible for follow-up activities in four areas:

a.) Medical Diagnosis and Treatment
Monitors were to assist clients in understanding the existence of a problem, in making appointments with appropriate medical providers for the duration of the problem, and in overcoming obstacles in keeping appointments for referrals originated by the Title XIX Screening Team.

b.) Repeat Tests
Upon the request of the screening team, monitors were to assist in getting clients to return to the screening clinic for retesting.

c.) Immunizations
Case Monitors were to assist clients acquire immunizations for children under seven years of age who were of incomplete immunization status at the time of screening according to guidelines of the Title XIX team and the American Pediatrics Association

d.) Dental Services
Upon receipt of individual authorization for dental services from the State Department of Public Welfare, monitors were to assist clients in making the initial appointment with a dentist. Monitoring responsibilities did not extend beyond the client's initial visit, though further treatment may be required.

SYSTEM MANAGEMENT

The Direct Services Supervisior had major responsibility for managing the case monitoring subsystem. Management of case monitoring required attention to several areas:

a.) Coordination with the regional EPSDT program-
Though the research sample was defined in the Project proposal and in subsequent written agreements, it was sometimes necessary to clarify whether an individual case was the responsibility of the Project or the regional program.

Also, in accordance with regional policy, the supervisor supplied the EPSDT Regional Coordinator with monthly statistics on clients referred in medical screening and/or requesting and receiving dental services.

b.) Staffing
The Direct Services Supervisor regulated all monitors' personnel matters inclusive of hiring, approval for sick and leave time, approval for reimbursement for travel expenses.

c.) Case assignment
Written notification for all client requests for services, Title XIX team requests for monitoring assistance, screening or immunization referrals were routed through the supervisor. Regulation is maintained for appropriate client/monitor assignment according to the research design and for surveillance of the volume of individual monitors' case loads.

d.) Supervision of monitoring performance
The supervisor was responsible for providing training and technical assistance to monitors on service provision procedures. He supplied letters, forms or other tools to monitors which were necessary for job performance. He held regular supervisory conference with monitors and provided guidance on individual case management upon request. The supervisor had major responsibility for evaluation of monitors in accordance with Department of Public Welfare policies.

SYSTEM CAPACITY AND UTILIZATION

As mentioned earlier, case assignment to the monitoring subsystem was dependant on activity in the casefinding subsystem. Definition of the demonstration project sample and casefinding assignments altered several times during the months covered in this report. To summarize briefly, the project sample size increased from 10% of the population in February to 20% in March to 40% in April. Casefinding for sample cases was performed by employees of the regional EPSDT program in Sector A of the project during the months of February through July and in Sector B during the months of May through July. Project employed student interns performed casefinding in Sector B during February through April. As of August 1, casefinding in Sectors A and B has been performed by project employed workers. Casefinding in Sector C has been performed by Aides employed by the Project throughout the period. It should be noted that casefinding of sample cases was the only responsibility of project employed students, Aides, and workers, wheras workers employed by the regional program were responsible for both sample cases and non-project cases. Controls were available to the project to assure a large degree of casefinding on sample cases handled through direct project supervision. The degree of casefinding on non-sample cases, those handled through the regional program, was not controlled or assured.

It appears that the above explanation was influential in the unbalance of caseloads that occurred between monitors in Sectors A, B and C. By far the largest number of cases who were outreached and as a result required monitoring services resided in Sector C. The following table is a summary of case assignment per monitor for the months of February through December.

Case Assignments Per Case Monitor

	SECTOR A SOCIAL WORKER			SECTOR B COMMUNITY SERVICE AIDE			SECTOR C NURSE (FEB-SEPT.) WELFARE SERVICE TECHNICIAN (OCT-DE		
MONTH	MEDICAL REFERRAL	IMMUN-* IZATION	DENTAL SERV.	MEDICAL REFERRAL	IMMUN-* IZATION	DENTAL SERV.	MEDICAL REFERRAL	IMMUN.*	DENTAL SERVICES
February	0	NA	NA	6	NA	3	--	2	NA**
ch	2	NA	NA	3	NA	11	10	NA	177
April	0	7	0	4	0	17	14	6	18
	0	8	4	2	1	8	19	6	46
June	9	6	21	1	3	14	30	7	128
July	9	12	15	5	6	25	15	6	86
ust	15	9	103	7	1	43	16	1	37
September	NA**	8	NA**	8	7	16	6	6	64
ober	6	8	70	NA**	15	NA**	3	12	69
November	2	6	29	6	8	41	10	7	52
December	5	NA	48	2	NA	47	11	NA	90

* Totals recorded are accurate for the 15th of the month reported in to the 15th of the following month.

** Information was Not Available (NA) for those months during which a position was vacant. The number of case assignments during a vacant months was combined into the totals of the following month.

The table represents new cases assigned per month. The caseload each month was comprised of both new cases and a smaller number of cases carried over for continued monitoring from a subsequent month (s). Though exact data per monitor on active caseloads is not available at the project, all monitors have reported that they have not reached their maximum capacity at any time during the report period. Data on case assignment and comments by monitors in Sectors A, B, the Social Worker and Community Service Aide, indicate that

these case monitors were extremely underutilized during the first five months of the project, During this period of underutilization in monitoring activities, the social worker reports spending 80% of her work time on Family Services which are not a responsibility of EPSDT. They report a slight increase in caseloads and time spent on case monitoring responsibilities in July, and more substantially in August but both feel they continued to work a great deal below their capacity.

Though the number of case assignments per worker in sector A & B expanded since July, one additional change occurred in October which slightly reduced all the case monitors case responsibilities. A new procedure was implemendted at that time in which a Department of Public Welfare Follow-up Worker was assigned the responsibility of initiating referral appointments immediately at the screening site. This procedure (previously performed by the monitors subsequent to the screen date) has had a small effect on decreasing the necessary time a monitor must spend with a client.

One Social Worker estimated that a caseload of 50 medical referrals in addition to dental and immunization referrals at the August rate or larger, would be an appropriate, effective caseload. The Aide was uncertain as to an appropriate estimate of optimum caseload. The monitors in Sector C, the Nurse and subsequently the Welfare Service Technician indicated that, though their case responsibilities adequately occupied their time, an even larger caseload would be realistic, and desirable.

Due to differences in caseload size and individual methods of case treatment, monitors report differences in proportion of time spent on specific activities. The following table lists the proportion of time in regards to full time employment spent per activity as estimated by each monitor.

Estimated Distribution of Time Spent Per Activity Per Monitor

	SECTOR A SOCIAL WORKER		SECTOR B COMMUNITY SERVICE AIDE		SECTOR C NURSE (Feb.-Sept.) WELFARE SERVICE TECH. (Oct.-Dec.)	
	% OF TIME SPENT ON:					
MONTHS	MEDICAL AND IMMUNIZATION	DENTAL SERVICES	MEDICAL AND IMMUNIZATION	DENTAL SERVICES	MEDICAL AND IMMUNIZATION	DENTAL SERVICES
Feb. - June	10%	10%	25%	75%	40%	60%
July - Sept	50%	50%	40%	60%	60%	40%
Oct. - Dec.	50%	50%	40%	60%	50%	50%

It should be noted that an additional factor influencing the change in distribution of time which occurred from one period reported to the other

was a policy change. Accordingly, as of July 1, less effort was required in dental monitoring.

RECORD KEEPING

Routinized forms are used for each component of case monitoring. These are: Medical Referral Form System 402, 402-1, 402S and Addendum Case Monitoring Sheet (Note: The 402 is a state department form. It's format has changed three times during this report period.)
Immunization Annex
Dental Approval Cards and Dental Monitoring Sheet
Copies of forms can be found in Appendix B

In addition, monitors use narrative recording for documenting case treatment in case folders. The Aide reports keeping additional records for case management purposes which are organized according to action dates, somewhat like an appointment diary. The nurse established a tickler file system for dental monitoring. The second social worker and second community service aide instituted similar card file methods for recording actions taken and status of each assigned client.

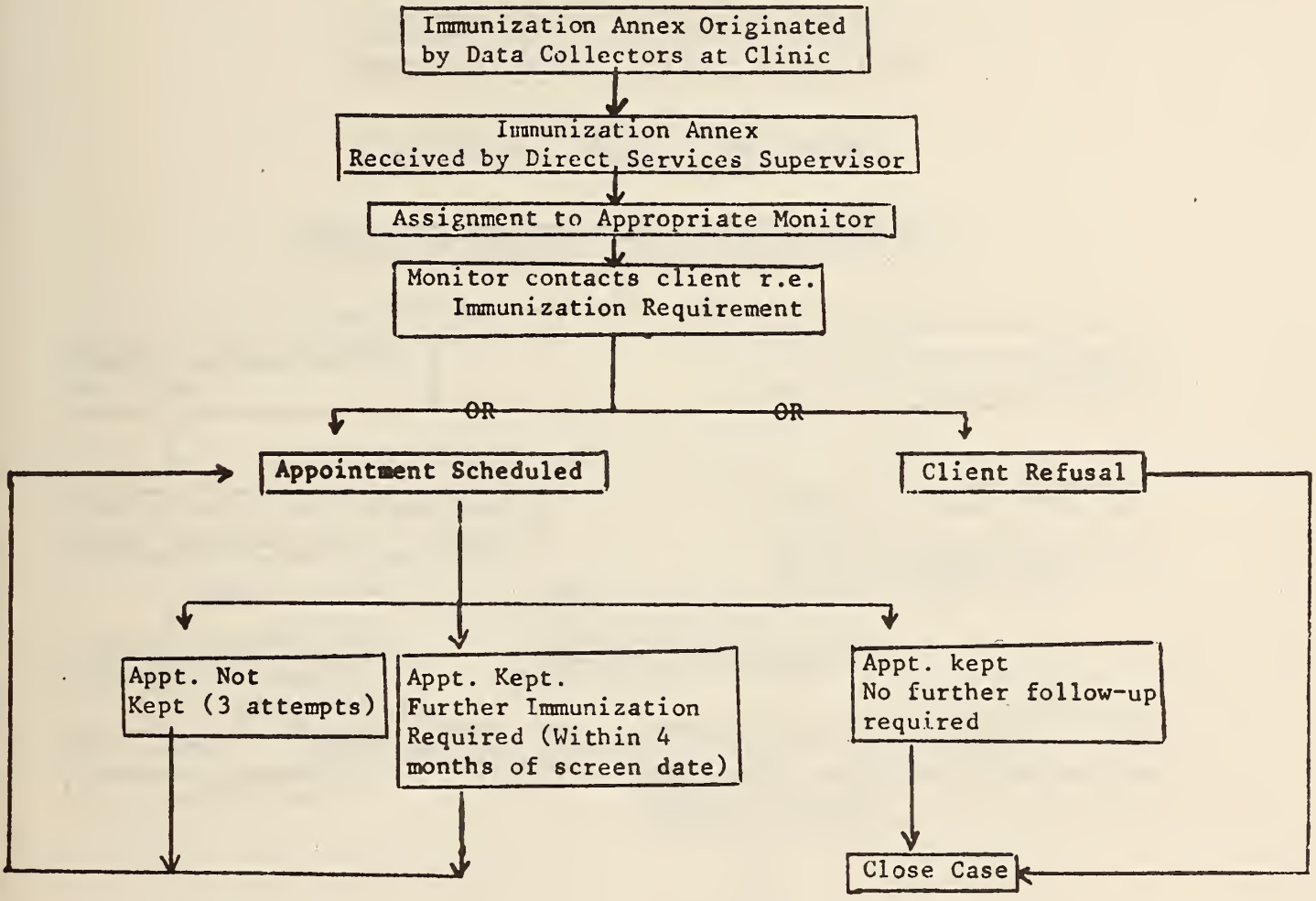
PROCEDURES AND TECHNIQUES USED IN CASE MONITORING

Management of the case-monitoring system dictated a specific set of case procedures which were fairly routinized among all case monitors. In contrast, specific techniques for carrying out procedures were not designated by management and were, rather, designed and implemented separately by individual case-monitors. Additionally techniques necessarily varied greatly depending on the nature of the problem and particular client. It is this great variability between cases that renders case-monitoring a non-fully developed technology. Therefore, case treatment was dependant on individual worker judgement and expertise.

Management procedures varied slightly between the various areas of responsibility of the monitors. The differences in management systems and worker techniques used in medical diagnosis/treatment/retests, dental, and immunization follow-up is described in the following pages. Brief background information and flow-charts are provided for Immunization and Dental system procedures. Emphasis has been placed in this paper on the description of procedures used in monitoring medical treatment/diagnosis/retest referrals. The narrative and flowchart on medical referrals distinguish routine management procedures from those areas in which individual techniques and judgements must be called upon. Also, it is important to note that an individual client may have required monitoring services in more than one area. The various needs were attended to by the same monitor often through communication concerning several problems during one client contact.

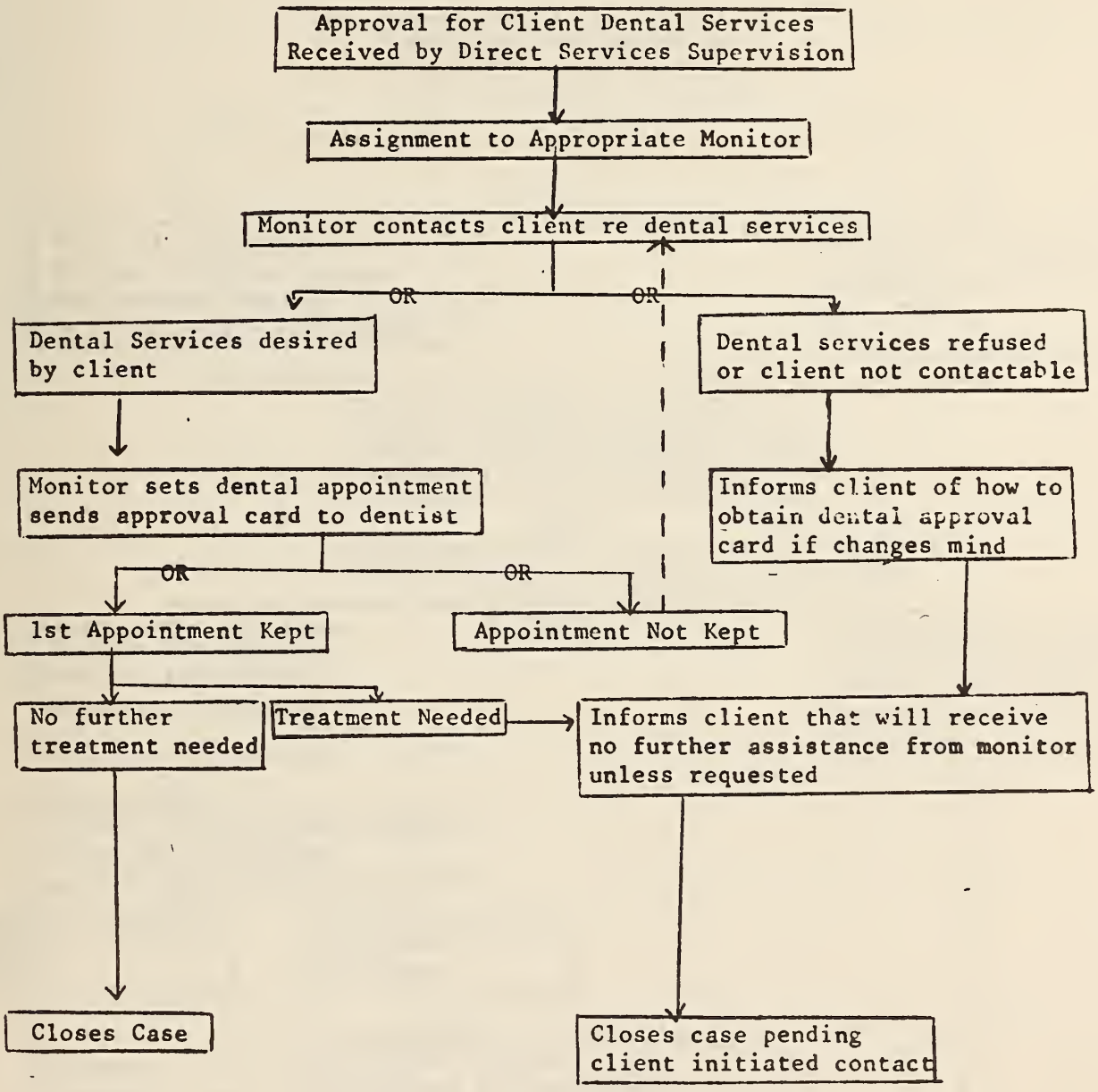
Flow Chart

Monitoring Procedures for Immunization Completion



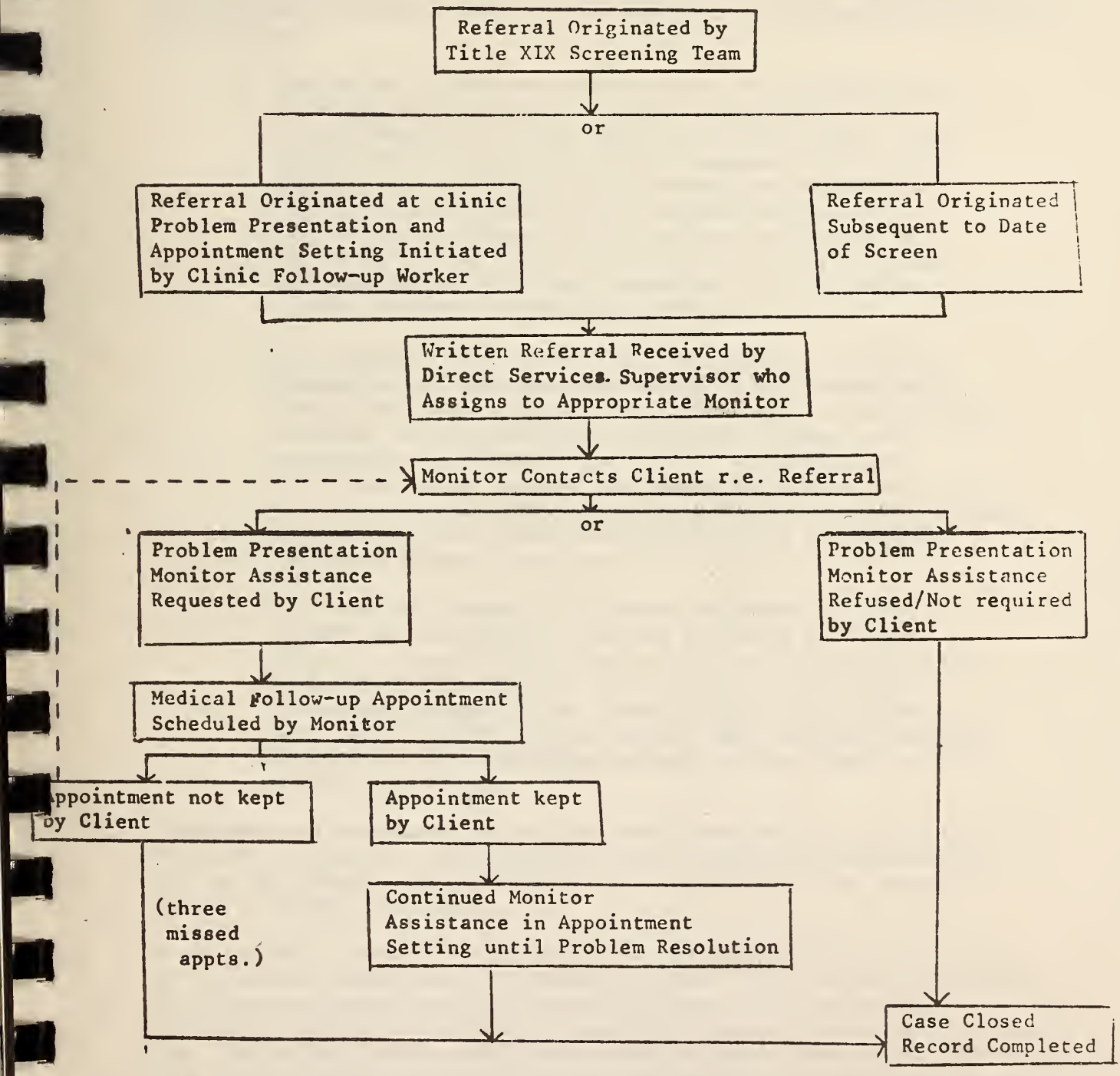
FLOW CHART

Monitoring Procedures for Dental Services



FLOW CHART

Monitoring Procedures for Medical Referral and Screening Retest



IMMUNIZATION FOLLOW-UP

The flow chart represents an idealized system for case monitoring of required immunizations which closely resembles the type and degree of efforts present in monitoring medical referrals and retests. In fact, three obstacles existed which created ambiguity in the immunization follow-up component.

a.) Completion of the immunization annex was dependant on information provided by the client (usually the head of the household) to a data collector at the clinic. Infrequently the client provided this information from a medical record. Usually, the information was obtained from the clients memory which caused a problem of reliability. Neither the data collectors nor two of the monitors were medical personnel, yet they were left with the difficult, if not impossible task, of establishing accurate immunization status.

b.) The screening team stated that they follow a policy of immunizing children who they establish as "incomplete." Though the data collectors and screening team used the same schedule for establishing immunization status, gray areas exist in which records are not available and the client cannot provide the necessary information. In this circumstance, the screening team often did not immunize, yet the data collectors interpreted such a situation as requiring further attention.

c.) If a monitor, indeed, did attempt to assist a client receive an immunization, she was likely to guide the client to immunization services available at Martin Luther King Clinic. This clinic has open hours rather than appointment times per se. Thus the definitions "appointment made" and "missed appointment" were unclear resulting in confused data recording and unclear conditions to indicate case closure.

Furthermore, a management policy was established which placed priority of the other monitoring responsibilities over immunization follow-up resulting in a minumum of activity in this area during the period of February through September.

As of October 1, policy redirected attention to immunization follow-up to be equal to other monitor responsibilities. Also, further definitions of the process were made. Follow-up assistance was provided for only those individuals who were incomplete on immunizations as of the date of screening. Individuals with questionable status were followed up on. The Dallas City Health Departments immunization bank began to be used routinely as an additonal resource for information though it also often lacked complete information due to its short life span. Monitoring immunizations consisted of a combination of letter, phone and personal contacts to inform

clients of the need for attention and of the availability of immunization services. At least one personal contact was always attempted to encourage those clients who did not respond to letter or phone information. Since no specific appointment setting was possible and the concept of "missed appointments" vague, the following list of circumstances for inability to complete immunization follow-up and rationale for closing a case was compiled:

- Family moved
- Family lost eligibility
- Refused to seek immunization services
- Worker was unable to contact family after numerous efforts
- Repeated unsuccessful attempts -
  At a minimum a monitor was to make one personal contact and send at least two letters to a client to inform them of details of available immunization services

Monitors report that immunization follow-up was the most difficult of their assigned responsibilities due to apparant client apathy.

DENTAL MONITORING

Prior to August 1, dental monitoring focused on treatment completion and occupied a majority of the monitors' time (See System Capacity and Utilization.) As of Augustl, a policy was adopted to limit monitoring efforts to treatment initiation as illustrated in the flow chart. This decision was based on the priority for medical monitoring established in the proposal for the first year of the demonstration project. In compliance with the continuation proposal for the second year, data on the current method of monitoring (as in flow chart) has been collected since September 1.

MEDICAL DIAGNOSIS/TREATMENT REFERRALS AND RETESTS

The steps in the following narrative correspond with the flow chart C on a previous page.

1) Referral Originated -- Referral for diagnosis, treatment and retests were originated by the screening team by use of a standardized Medical Referral form on which client identification information and reason for refferel were recorded. When a client required a retest only, notation was made on the form that the client need only to return to the screening clinic. Monitors assisted with a very small number of required retests due to the screening team's policy of making initial attempts at client contact. Notification was sent to monitors only when the initial attempts to obtain a retest were unsuccessful.
   Prior to October, at which time a new procedure was adopted, written records of referrels were sent by the screening team to the Welfare Department. Communication beyond basic

problem identification was sometimes passed on to workers by written 'editorial' type comments on the form. For instance, the screener may have indicated a need for priority attention or may have suggested an appropriate medical resourse. Welfare Department Workers, upon reception of the form, initiated follow-up procedures.

In October, the Welfare Department assigned a clinic follow-up worker to initiate follow-up procdures immediately at the clinic site. Those problems identified during the time of screening were referred to the follow-up worker. The follow-up worker was responsible for explaining the referral to the client with a nurses assistance if warranted and for arranging an initial appointment with a medical provider on the spot. Those referrals resulting from laboratory testing were handled according to old procedures.

2) Case Assignment -- Written records of referrals were sent by the screening team to the Direct Services Supervisor. Prior to employment of the clinic follow-up worker, referrals which were originated on the date of screening were received approximately one to two weeks later. Beginning in October, records of referrals on clients for whom the clinic follow-up worker initiated services were received by the Project within one or two days of origination.

Referrals originated as a result of abnormal laboratory tests were usually received approximately three or more weeks after the screening date. Records of the screening visit (Texas Dept. of Health Resources Form 400) were received by the supervisor four or more weeks after the screen date also. Though it is state policy that a record of the screening visit simultaneously accompany the referral to the worker (and subsequently to the client) this policy was not enforced during this period. The supervisor assigned referral cases to the appropriate monitor and supplied them with the referral form, and screening report (when available.) The DPW client case folder was obtained by the monitor through the case-finder who outreached the case or through the records division.

3) Original Client Contact -- Upon assignment of medical referral cases, a first decision that a monitor had to make was in regards to case priority for attention. All the monitors established the common practice of providing services to those cases which they established as critical first. Since the screening team informed workers of acute emergencies in only a small number of cases, it was most often necessary for a monitor to set priorities according to their own judgments. The social workers and nurse indicated that they relied most heavily on their own experience and knowledge in order to determine which cases were critical. The Community Service Aides and Welfare Service Technician indicated that their recent experience alerted them to the critical attention required by certain

types of referrals but in addition, they commonly sought advice in this area from the Project Health Coordinator, a registered nurse with project administrative and educational responsibilities. Beyond making immediate follow-up contacts with critical cases first, one social worker indicated she bypassed her usual attempt to make a home visit in these instances. She estimates that this mode of action was necessary in less than 10% of her cases.
Upon employment of the clinic follow-up worker, the necessity for establishing priorities was lessened due to the fact that most referred clients had received initial follow-up services while still at the screening clinic.

The usual methods used by all three monitors to discuss referrals with clients were phone calls, home visits and letters used in various combinations. Most commonly, if a client had a phone the monitor called to arrange a time for a home visit and then made the personal contact at the appointed time. The Community Service Aide and Nurse normally made calls several days prior to the date they would like to visit wheras the social worker more commonly called and visited on the same day. Often the nurses and Aides methods entailed a second call to confirm the visit on the day agreed upon. The social workers and nurse made inquiry over the phone as to whether the client was aware of the problem or had sought treatment and terminated cases over the phone if the problem resolution was idicated by a client. The Aides placed greater dependance on home visits. The initial contacts a monitor had with a client since the participation of the clinic follow-up worker indicated that a minority of clients kept and completed treatment appointments as a result of only the follow-up worker's assistance.

For those cases which could not be reached by phone, letter communication took place. The Nurse preferred to send a letter which stated simply "Please call me at (phone#) before (date.) I need to talk with you." The nurse remained available at the office to receive such calls several days per week. She indicated that those who were most likely to follow through on treatment most often returned her call. If no call was returned, another letter was sent out indicating she would visit the clint's home on a specific date. The nurse indicated that once her efforts had reached this stage, it was unlikely she would be able to make contact with a client. The social worker more often used the second type of letter right away or simply made a visit without any prior notice. She did not determine which approach was more successful at finding clients home. The community service aide also used both letters but in reverse order of the nurse. That is, a letter with a proposed visiting date was sent, then a home visit made. In those cases which she did not find

home on her first attempt she left a note or sent a letter requesting that the client call her. Combination of calls, letters and visits were used continuously until the monitor was able to contact a client or until she established after at least three home visit attempts, that the client could not be located. For those cases which were epecially difficult to contact, the monitor used her own judgment of when to close the case taking into consideration the seriousness of the problem. Once case aide indicated that she regularly received messages or information from neighbors of a client which encouraged her to continue pursuing a case. Furthermore, the Aide, and the Welfare Service Technician on occasion, made visits to clients after working hours and on Saturdays.

4) Problem Presentation -- Prior to employment of the clinic follow-up worker, the original contacts which a monitor made with a client as described above were mainly in preparation for problem presentation. This more in depth problem presentation occured in most cases during a home visit.

When the follow-up worker became a part of the procedure, original contacts often were made to establish the status of the referral appointment made at the clinic.

The monitors believed that the home visits provided more condusive settings for better client understanding of a problem than letter or phone communications. In addition to serving as a statement of monitor's sincere concern for a family, monitors indicated that their ability at explanation was enhanced as was their ability to make judgments concerning the individual needs of a specific client. The Social Worker indicated that she relied almost solely on the reason for referral and impressions of a client at the home visit to determine a course of action. The Community Service Aide depended additionally on DPW case history records. All monitors appeared sensitive to a negative, cautious viewpoint about the Welfare Dept. they felt was held by clients. The Community Service Aide and Welfare Service Technician in particular, stressed that they put a good deal of initial effort into clarifying their function with the Department and the lack of threat that position carries.

The monitors displayed different styles in their communications about the problem with their clients. Presentation of a problem with a client always entailed discussing the nature of the problem, whether any treatment had already been received, whether the client desired to seek care, and where and when she desired to seek care. Further insight into personal styles and additional items exchanged between clients and each worker may be obtained from the

comments in the conclusion section.

5) Appointment Scheduling -- In most instances the monitors (rather than the clients themselves) scheduled appointments for the client if one was desired. All three monitors inquired of the client whether they have a family doctor or a resource they prefered to use. Sometimes the monitor suggested a different resource (or an original one if one was not established by the client or follow-up worker at all.) Suggestions depended on the individual monitors knowledge of available resources to fit different health needs, the monitors personal experience with individual providers, and whether the clinic follow-up worker had already initiated an appointment with a provider. The monitors sometimes shared names of resources with each other as well as impressions of the quality of care available from specific providers. The monitor usually presented the name of one or two of the "best" resources appropriate for problem treatment even though the available resources known to them may have been more numerous. In the majority of instances it was the monitors suggestion to which the client agreed.

Thus monitors were highly influential in both what type of provider resource clients utilized as well as what individual providers within a specialty or type were more frequently used. For instance, a vision referral was most often scheduled at an optical clinic by the nurse because she stated she felt they were easy to get to and familiar to clients. The Aide always scheduled vision referrals at an opthamalogist unless the client already had an up-to-date glasses prescription. This was based on her judgment of where one can receive better quality medical care. Following is a table of the numbers and types of medical resources which each monitor knew about and had the option of suggesting to a client.

Social Worker	Community Service Aide	P. H. Nurse
2 Pediatricians	1 Pediatrician	2 Pediatricians
Children's Medical	Children's Medical Ctr.	8 Family Practioners
Parkland Hospital	(Individual Clinics)	1 Urologist
1 Osteopath	Parkland Hospital	1 Neurologist
1 Psychiatrist	Oak Cliff Eye Clinic	CMC Clinics
MHMR	(Opthamology)	Parkland Hospital
3 Optical clinics	2 Optical Clinics	3 Opthamalogists
1 Opthamology clinic		3 Optical Clinics

6) Continued Surveillance -- The nature of the problem, client characteristics and worker characteristics were all influential in the length of time surveillance of a referral continued and in frequency of contacts during the surveillance period.

Contacts which necessitated any appointment setting or verification of appointment keeping were made routinely by all workers as demanded by the situation. Additional contact, specifically home visits, were made by the first community service aides in order to further enhance repoire, understanding, and the general relationship between the aide and a client. One social worker made additional contacts in instances in which assistance beyond medical care was indicated by a client. The social worker discussed and/or referred clients for assistance in the following areas-housing, legal aide, food stamps, day care, rehabilitation, work incentive program. The Aide and Welfare Service Technician indicated that they had a good deal of opportunity to assist clients in these areas but felt they had an inadequate knowledge of information and referral resources.

7) Case Closure -- A case remained active in a monitors case load until one of the following situations occured:

   a.) Medical treatment terminated by resource-treatment completion.
   b.) Family moved.
   c.) Family became ineligible.
   d.) Six months lapsed since referral date and client was able to continue seeking treatment on her own.
   e.) Monitor was unable to contact client after repeated attempts.
   f.) Client repeatedly missed appointments.

CONCLUSIONS AND PROGRAM IMPLICATIONS

The demonstration of three different levels of case monitors was limited by the limited example of workers per level. Even so, each monitor indicated that they experienced specific frustrations and fulfillments in performing their jobs which can be attributed to their singular type of training, experience and orientation. As discussed in the previous sections, the casemonitoring management system provided a limited degree of structure in job performance. But completion of monitoring responsibilities was dependant on numerous individual monitors decisions, judgments and techniques. A summary of those areas requiring individual monitor attention follows. The summary is, in turn, followed by concluding statements concerning each monitor's strengths, weaknesses and general job perspective as observed by the system managers and monitors themselves.

SUMMARY OF AREAS REQUIRING APPLICATION OF INDIVIDUAL MONITOR TECHNIQUES

a.) Prioritization of cases -- The monitor must decide which assigned area of responsibility should receive priority

and which case, based on problem severity, requires first attention. Decisions may be based on personal experience, information in case records or supervisory assistance.

b.) Preference in method of contact, both original and on-going.

c.) Assessment of client's iniative and degree of independance in acquiring medical care. Actions of a monitor are influenced by their perception of a client's willingness to seek services and the problem severity. The greater the monitor judges the severity the more likely she is to assert her own beliefs and apply methods of persuasion to a resistant client. And vice-versa, a problem which a monitor assesses as resolved since the screening, very minor, or under adequate home treatment may receive little assertive action by the monitor which encourages client scheduling at a medical resource.

d.) Acquisition of health related resources and assessment of appropriateness to specific problem.

e.) Assessment of when to close a case -- The monitor bases this judgment on communication with the client and/or provider and on the severity of the case.

f.) Application of techniques for assisting clients in easier acquisition of services -- In order to assure that needed attention is given to a health problem, monitors are placed in a position of eliminating barriers to receiving care which a client may confront. Alleviation of barriers may include assisting clients in their ability to acquire additional resources, i.e.; transportation, child care as well as assisting clients to understand and accept the need for attention and the process which they will undergo in receiving it. In addition, services other than EPSDT, health related are often required by clients. The close connection of EPSDT with other Department of Public Welfare Programs makes information and referral services provided by a case monitor very valuable to a client.

SOCIAL WORKER

The social workers' overall perspective of the case monitoring position is that it is appropriate for individuals of their type and degree of training. Both have qualifications to make on this opinion, though. They indicated that lack of fulfillment in this position could be easily

generated by their being under-utilized and over-specialized. One of the social workers used the phrase "counselor and advocate" to describe the appropriate performance role of a monitor. They felt that in order to perceive the needs of a client, a monitor must have a "gestalt view" of the client. A monitor must be aware of the many factors and problems influencing a client's life rather than perceiving the client as a medical referral. Counseling and advocacy functions can be performed only if a monitor is knowledgeable in the area of information and referrals. The monitor must have an awareness of available medical resources as well as of an array of social services. These should be used to improve a client's access to medical resources, or more generally to meet non-medical needs and hopefully improve their living status.

The social workers applied their own judgments freely in establishing the severity of a case and in applying varying degrees of assertiveness in their work with clients. For example, a teenage girl who was referred for a problem of overweight was assessed by the monitor to be safely and conscientiously dieting and to have a mother who was not highly motivated in seeking professional help for her daughter. The social worker advised the girl not to see a doctor but to contact her if the diet caused problems and if professional help was desired at a later date. The social worker in essence, provided diet counseling to the girl herself. This action on the part of the social worker can be construed in several ways. On the one hand, by acting professionally, she saved the client the trouble and reduced Medicaid expenditures for "unnessary" treatment. Conversely, though not trained in the medical profession, she made a medical decision which revised the assessment for required treatment made by the screening team, those who were formally recognized as the appropriate medical decisions makers.

The social workers consider the ability and freedom to make this type of judgment necessary to optimally perform case monitoring. The opportunity for them to use professional judgment is necessary in order for them to feel that their skills are being utilized. Both social workers feel that a greater expansion of responsibilities would enhance the job satisfaction of a social worker in a monitoring position. One suggested some specific tasks which include researching and expanding available medical resources, and providing input into management decisions.

One social worker experienced frustration in meeting recordkeeping requirements though the other felt most confortable in keeping a meticulous organization.

In conclusion, an experienced social worker is an individual trained in and practicing professional decision making. This professionalism has consequences on the program in which it is applied:

1. the program must provide opportunity and freedom for a social worker to utilize his/her skills. If this opportunity is not offered the likelihood of job dissatisfaction and worker turnover is increased.

2. the program must retain goals which are compatable with individualized worker decision making. If an EPSDT program aims to acquire medical services for all clients referred at screening, the social worker's decision to avoid seeking medical care for a client is incompatible.

If individualized decision making is not a goal of EPSDT case monitoring; a less experienced level of personnel or monitor with a non-professional orientation may prove to be more cost-effective.

COMMUNITY SERVICE AIDE

Both Community Service Aides had as a major objective in their job performance, building a good rapport with their clients. This was achieved by a self-applied rule of making home visits to all clients, and by a willingness to visit clients outside regular work hours, (this ability was increased due to residency within the targe community). One Aide established the custom of visiting clients specifically in order to build communication in addition to visits for appointment setting purposes. The Aide felt that these increased contacts offered her the time to better understand a client's needs, and to discuss medical referrals and dental services on an informal, leisurely basis which improved client's understanding of problems and available services. It was a practice of both Aides to leave a business card with every client.

The Aides felt that use of these techniques made them successful at increasing rapport and consequently of increasing job satisfaction. A result of the greater rapport was that, commonly, clients informed the Aides of numerous problems and needs for services outside of the area of EPSDT. Though this occurrence was present in the job performance of the social worker and nurse as well, the Aides increased amount of time with each client increased the probability of its occurrence. An example of this phenomenon is illustrated by an eighteen year old client for whom no referral was originated but whose request for dental services required attention by a Community Service Aide. As mentioned, it was the practice of this Aide to make home visits to all clients whether they required detailed medical referral assistance or routine dental services, as in this instance. It was at the home visit to this client that the monitor learned she had been diagnosed as an infant as a possible cerebal palsy case. She was totally immobile, cared for by her family and her mother claimed she was unable to obtain help for her daughter from a social service or medical organization. After consultation with her supervisor and the Project Director, the Aide was able to initiate the involvement of the Cerebral Palsy Association with this family.

It is important to note that in this case, as well as in those less dramatic, the Aide required both judgmental and informational assistance from managerial personnel. It is precisely in this area of information and referral that both Aides expressed feeling the most inadequate. The organization of the monitoring system and project management afforded

her a great deal of opportunity in acquiring assistance when requested. But the Aides indicated that they refrained from requesting help in all instances in which a need came to theirattention and was often faced with telling a clientthey really couldn't help her in that area.

The Aides supplemented their required record keeping with their own system of notetaking or file cards andwere therefore able to complete forms with a good deal of accuracy.

Program implications which the above characteristics of an Aide have are as follows:

1) Program goals must be examined with consideration given to an Aide's heightened rapport and involvement with clients. Specifically, the desired degree of integration with other social service departments and agencies must be determined in connection with the degree of emphasis on information and referral which is necessary to overcome case monitor's feeling of inadequacy.

2) The Aide requires training in monitoring skills as well as close supervision. It is important that a program employing Aides have adequate staff for close supervision and provide an Aide opportunity for comprehensive training.

PUBLIC HEALTH NURSE

The nurse conceived her monitoring responsibilities to be assisting clients receive medical care as prescribed by the Title XIX Screening Team. Involved in assistance is helping clients understand the medical problem, acquiring resources and medical appointments for clients, providing transportation to aid in client's reception of services as needed.

In assisting clients understand their particular medical problem the nurse often sent brief written explanations to clients as part of her client contact and problem presentation procedure. She reports that she made some attempts at medical explanations on her home visits but felt the clients comprehension of these was minimal. It is from these experiences that the nurse concluded that the limited amount of medical detail required by a client to have a satisfactory amount of knowledge does not necessitate the more advanced medical knowledge of a nurse.

The nurse was very successful in accessing medical resources to whom she could refer clients. Her systemized use of various providers and good rapport can be exemplified by an arrangement she made with a local dentist. The nurse arranged a regular day each month on which she assessed his office records to obtain information concerning her client's received dental services. This action when possible, took the place of a client contact to obtain the information. In addition to alerting the nurse to additional action required of her, this type of technique enabled her to keep both dental and medical records complete and up-to-date.

The nurse indicated that she encountered a number of referred clients who did not sucessfully make and keep appointments with medical resources though she had assisted them during home visits. Often these clients required services which the nurse, herself, was qualified to give. Thus, the nurse had a select, captive audience during a home visit whom she could have treated if treatment was under her jurisdiction. Since it was not, these (the number is unkown) were required to travel to another medical resource and possibly did not seek or receive services at all. In the configuration of the domonstration project, the nurses training and expertise were not used in communications with clients nor in potential areas for treatment. This created a most unsatisfying job experience.

Furthermore, the nurse, as the other monitors, was questioned by clients concerning other social service needs. She was very unprepared to offer information and referral services in this area. The nurse concluded that in this confirguration of monitoring, she was over-qualified in the medical aspects, under-qualified in the social services aspects and not appropriately employed.

The program implications in this instance are obvious:

1.) A nurse may be appropriate as a case monitor if given responsibilities other than those assigned in this configuration.

2.) Employment of a nurse as a case monitor requires a program to provide further training in the area of social services.

Potential exists for employment of a nurse in a different configuaration than demonstrated during this period. One possibility is to employ a nurse with responsibility for performing retests, medical counseling/education and other home treatment to clients. In examining this possibility, consideration must be given to the type of referrals which are prevalent and whether there is an adequate number of referrals of the type that are amenable to home treatment. Also, if this configuration appears plausible, consideration should be given to employing a nurse with less education than an R.N. perhaps an individual such as an LVN whose full potentials would be used. Finally, it is most important to acknowledge that the broader use of a nurse case monitor in the screening or treatment process would require renegotiation of current Dallas EPSDT policies.

Another possibility for employment of a nurse in the follow-up process is to utilize a nurse's demonstrated skills in building repoire with other medical personnel. One potential area in which EPSDT could share coordination and service provision is school nursing services. Further examination of implementing the services of a nurse in a new configuration at the Demonstration Project is warranted.

WELFARE SERVICE TECHNICIAN

It is most difficult to draw even theoretical conclusions concerning the potentials and cost-effectiveness of a Welfare Service Technician in a monitoring position at this time for several reasons: First, the position has been effective for the brief period of only three months. Second, there are only minor differences between a Community Service Aide and a Technician. It is not a requirement that the Technician reside in the target area. Note though, that the Technician did previously serve as an Aide monitor, did reside in the Project target area and did rely on this situation in her job performance. The Technician is required to have some earnings in the higher education system and does receive a greater salary than the Aide. The technician in the demonstration had established personal procedures and idealogies while serving as an Aide before her promotion. She herself stated that the only change which has occured in her job since her promotion has been her clients. Though she had nothing to report regarding the potential of being a Welfare Service Technician rather than an Aide, her record of successes in monitoring may have changed as a result of her expanded education and experience and may be reflected in case completion data.